EXHIBIT 72

10m 5500

Corporation of the Treasury or toroid Revenue Service Corporation of Liber Surveyor and Wedland Remains

Pension Benefit visuality Corporation

Annual Return/Report of Employee Benefit Plan

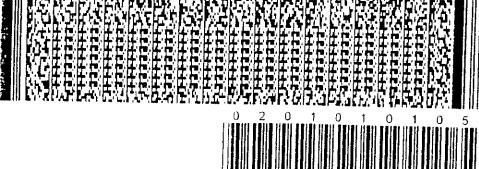
This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

 Complete all entries in accordance with the instructions to the Form 5500. Olbical Use Oray OMB Nos. 1210 - 01) (1 1210 - 0089)

2001

This Form is Open to Public Inspection

Part Annual Report Identification	Information		Pub	HC Inspection
For the calendar plan year 2001 or fiscal plan year	beginning			
A This return/report is for (1) a multiemployer		and ending		
			mployer plan; or	
	er plan (other than a	(4) 🔲 a DFE (spec	aify)	
multiple-employe	r pian);			
B This return/report is: (1) the first return/re				
	port filed for the plan;	(3) the final retu	rn/report filed for the pla	an;
(2) ☐ an amended retu → If the plan is a collectively-bargained plan, check he	#n/report;	(4) 🔲 a short plan	year return/report (less	than 12 months:
1) It filling under an extension of time at the Control	re			
D If filling under an extension of time or the DFVC prox Part II Basic Plan Information extension	<u> ram, check box and attach requ</u>	ired information (see instru	ictions)	
Part II Basic Plan Information ente 1a Name of plan	r all requested information.			
DIAGNOSTIC & CLINICAL CARDIOLOGY	,	1b	Three-digit	
P.A. MONEY PURCHASE PLAN	<i>i</i> ,	<u> </u>	plan number (만시) 1	002
THE TOTAL PONCHAGE PLANT		1c	Effective date of plan (mo day vr \
		04/	01/1976	
2.3. Plan spongar's purposed at 1				110 (110 Ki :::
2a Plan sponsor's name and address (employer, if for	a single-employer plan)	2b	Employer Identification	Number (EIN)
(Address should include room or suite no.) DIAGNOSTIC & CLINICAL CARDIOLOGY	,		22~232	3990
P.A.	,	2c	Sponsor's telcohone no	umber
			973-731-	
		2d	Business code (see ins	structions)
769 NORTHFIELD AVENUE				1111
100				
		History (1) Participal		
VEST ORANGE				Milabilan in h Milabilan in h
	NJ 07052	2		
Caution: A penalty for the late or incomplete filing of this	return/report will be assessed u	niess reasonable cause is r	established.	
Under penalties of perjuly and other penalties set forth in the instru s the electronic version of this return/report if it is being filled electronical	ictions, I declare that I have examined this ally, and to the best of my knowledge and	s return/report, including accompa-	nying schedules, statements :	ind attachments as we
	.,	owner, it is now, contect and compl	Ale.	
Ω				
Section 1 1 2	,	CRISCITO, M.D.		
, Signature of plan administrator	Date Typeo	d or printed name of individual	ual signing as plan adm	inistrator
Signature of employer/plan sponsor/DFE		RISCITO, M.D.		
	Date Typed or printe	d name of individual signing as en	nployer, plan sponsor or DFE	as applicable
or Paperwork Reduction Act Notice and OMB Contr	ol Numbers, see the instructi	ons for Form 5500.		m 5500 (2001)
			, ,,	0000 (2001)
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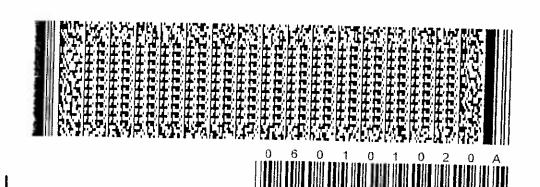




Form 5500 (2001)	Page 2		
3a Plan administrator's name and address (If same as plan sponsor, enter "Same")			Official Use Ordy
SAME	3b Admini	strator's	EIN
	3c Adminis	strator's	telephone number
	19 2 12 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		receptione number
If the name and/or FIN of the plan and	10000000000000000000000000000000000000		s Travillere Benada
If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plane EIN and the plan number from the last return/report below: a Sponsor's name	n, enter the name,		b EIN
			C PN
Preparer information (optional) a Name (including firm name, if applicable) and address			
MERICAN PENSION CORPORATION			p EIN
1375 PLAINFIELD AVENUE			22-21411
VATCHUNG			C Telephone numb
9J 07069			908-757-51
Total number of participants at the beginning of the plan year. Number of participants as of the end of the plan year (walface also		6	
		+	
d Active participants	•	72	
and an arrange bound to the state of the sta		7a 7b	
Total. Add lines 7g and 7e		7e	
Fermi parks that account baidings as of the end of the plan year (and district		7f	2
complete this item) Number of participants that terminated employment during the plan year with accrued benefits that we	rate and the	7g	2
		7h	
participants required to be reported as a Color of the control of separal	led	1	
Benefits provided under the plan (complete 8a through 8c, as applicable)		7i	
X Pension benefits (check this box if the plan provides pension benefits and an arrangement of the plan provides pension benefits and arrangement of the plan provides pension benefits and arrangement of the plan provides pension benefits and arrangement of the plan provides pension benefits are also as a pension benefits.		<u> </u>	
Characteristics Codes winted in the	on feature codes fr	om the	List of Plan
Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare Characteristics Codes printed in the instructions):	feature codes from	n the Lis	J LJ st of Plan
Fringe benefits (check this box if the plan provides fringe benefits)			
Things benefits (criteck this box if the plan provides fringe benefits)		<u> </u>	J []
Fight (URG)nd arrangement (check all that an +)	ment (check all that	apply)	
Plan runding arrangement (check all that apply)		.,,,,	
(1) X Insurance (the ck all that apply) 9b Plan benefit arrange (1) X Insurance			
(1) X Insurance (2) Code section 412(i) insurance contracts (3) Plan benefit arrange (1) X Insurance (2) Code section 412(i) insurance contracts		ontract	8
(1) X Insurance (2) Code section 412(i) insurance contracts (3) Code section 412(i) insurance contracts	n 412(i) insurance o	ontract	\$



		Page 2	Official Use Only
	(a) Name and addr persons to whom	ess of the agents, brokers or other commissions or fees were paid	The state of the s
(b) Amount of commissions paid		Fees paid	(e)
	(c) Amount	(d) Purposc	Organizatio code
	(a) Name and addre	ess of the agents, brokers or other	
	(a) Name and addre	ess of the agents, brokers or other commissions or fees were paid	
	(a) Name and addre	ess of the agents, brokers or other	
(b) Amount of	(a) Name and addre persons to whom	ess of the agents, brokers or other	(e)
	(a) Name and addre	ess of the agents, brokers or other commissions or fees were paid	(e)
(b) Amount of	(a) Name and addre persons to whom	ess of the agents, brokers or other commissions or fees were paid Fees paid	(e) Organization
(b) Amount of	(a) Name and addre persons to whom (c) Amount (a) Name and addre	Fees paid (d) Purpose	(e) Organization
(b) Amount of	(a) Name and addre persons to whom (c) Amount (a) Name and addre	Fees paid (d) Purpose	(e) Organization
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(b) Amount of	(a) Name and addre persons to whom (c) Amount (a) Name and addre	Fees paid (d) Purpose	(e) Organization



	Page 3	
F	Part II Investment and Annuity Contract Information	distract than Carly
_		
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be purposes of this report.	e treated as a unit for
3	Current value of plan's interest under this contract in the general account at year end	
4	Current value of plan's interest under this contract in separate accounts at year end Contracts With Allocated Funds	
5	Contracts With Allocated Funds	
а	and a property of the with the bish. Oh life	
L	Premiums paid to carrier	
C	A command and pure michain of the GIM of the Aeal.	120
d	with during a vice, of other organization incurred any specific costs in connection with the appropriate	
	or retention of the contract or policy, enter amount	
	Specify nature of costs ► N/A	[
е	(1)[1] morecast (2) group deferred annuly	
	(3) Other (specify)	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here	
6	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract (1) deposit administration (2) immediate participation guarantee	
	(3) guaranteed investment (4) other (specify below)	
L	>	
p	Balance at the end of the previous year	
С	Additions. (1) Contributions deposited during the year	
	(2) Cividends and credits	
	(3) Interest credited during the year	
	(4) Transferred from separate account	
	(5) Other (specify below)	
	(6) Total addition	
d	(6) Total additions	<u> </u>
e	Total of balance and additions (add b and c)6))	
~		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	
	(2) Administration charge made by carrier (3) Transferred to separate account	
	(3) Transferred to separate account (4) Other (specify below)	
	•	
	(5) Total deductions	
F	Balance at the end of the current year (subtract e (5) from d).	
	Cap noise for the contract of	



	If more than one contract covers the same group of employees of the same employer(s) or members of employee organization(s), the information may be combined for reporting purposes if such contracts are us a unit. Where individual contracts are provided, the entire group of such individual contracts with each treated as a unit for purposes on this report.	
7	Benefit and contract type (check all applicable boxes) a	d Life Insurance pyment h Indemnity contract
8	Experience-rated contracts	Part of the State
a	Premiums: (1) Amount received	
	(2) Increase (decrease) in amount due but unpaid	
	(3) Increase (decrease) in unearned premium reserve	
	(4) Earned ((1) + (2) - (3))	
b	Benefit charges: (1) Claims paid	
	(2) Increase (decrease) in claim reserves	
	(3) Incurred claims (add (1) and (2))	
	(4) Claims charged	• •
С	Remainder of premium: (1) Retention charges (on an accrual basis)	
	(A) Commissions	
	(B) Administrative service or other fees	_
	(C) Other specific acquisition costs	
	(D) Other expenses	
	(C) Taxes	
	(F) Charges for risks or other contingencies	
	(G) Other retention charges	
	(H) Fotal retention	
	(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	
	(2) Claim reserves	
	(3) Other reserves	
e	(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)	
3	Nonexperience-rated contracts:	
a		
b	Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition	
	or retention of the contract or policy other than reported in Part 1 item 2 above secret.	
	or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	. [
	Specify nature of costs	



SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2)

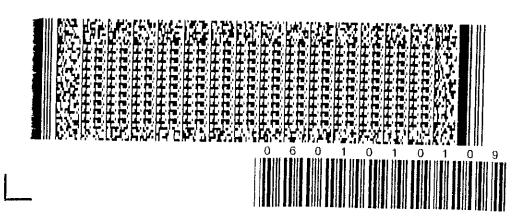
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OMB No. 1210-0110

2001

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For calendar year	2001 or figorial	and the same of th					muc mzbection
For calendar year :	zoo i or iiscai pi	an year beginning			and ending		
A Name of plan DIAGNOSTIC	& CLINICA	AL CARDIOLOGY, P.A	MONE	PURCHASE PL	AN	B Three-digit	002
C Plan sponsor's	name as show	n on line 2a of Form 5500					
DIAGNOSTIC	& CLINICA	AL CARDIOLOGY, P.A					
				0		22-2	323990
	ilda infarmation	oncerning Insurance C	ontract	Coverage, Fees	, and Com	missions	
rio	nue information	for each contract on a separate	Schedule.	 Individual contracts 	grouped as a	unit in Parts II and III e	can be
Tepo	uted on a single	Schedule A.					
1 Coverage:						······································	
							
		(a)	Name of i	nsurance carrier			
PROVIDENT N	MTUAL						
(b) EIN	(c) NAIC	(d) Contract or	(e) /	pproximate number o	l persons	Policy or co	ontract year
	code	identification number	covere	at end of policy or co	ntract year	(f) From	(g) To
							19/10
		4024790			1	01/01/2001	12/31/2001
2 Insurance fees brokers and oth	and commissior er persons indiv	is paid to agents, brokers and o idually in descending order of th	ther person re amount i	s. Enter the total fees aid in the items on the	and total com		agents,
				als			
	Total amour	nt of commissions paid			T-4-11		
					i otal i	ees paid / amount	
	O		j		_		
os Programasti Ci-	44				0		
or caherwork ice	uuction ACL No	tice and OMB Control Number	ers, see th	Instructions for Fo	rm 5500.	v4.1 Schedule	A (Form 5500) 2001



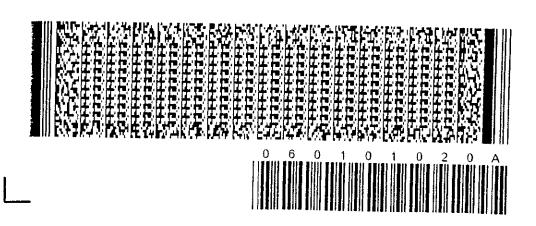
Schedule A (Form 5500) 2001 Page 2 Official Use Only (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid (b) Amount of Fees paid (e) commissions paid Organization (c) Amount (d) Purpose code (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid (b) Amount of Fees paid (e)

	(a) Name and address persons to whom co	s of the agents, brokers or other ommissions or fees were paid	
		o, icos vicia pud	
(b) Amount of commissions paid		Fees paid	(e)

(d) Purpose

Organization

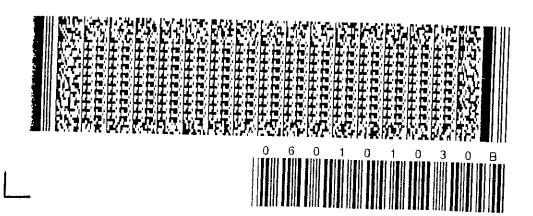
code



(c) Amount

commissions paid

Page 3	
Part II Investment and Annuity Contract Information	ासिका Use Only
Where individual contracts are provided the patients	
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be purposes of this report.	treated as a unit for
Current value of plan's interest under this contract in the general account at year end Current value of plan's interest under this contract in the general account at year end	
4 Current value of plan's interest under this contract in separate accounts at year end 5 Contracts With Allocated Funds	
5 Contracts With Allocated Funds	
a State the basis of premium rates DON FILE WITH THE DEPT. OF INS.	
b Premiums paid to carrier C Premiums due but unpaid at the end of the uncertainty of th	
the same and same at the clift of the Affilia	
of three organization incurred any specific costs in connection with the	
at recently of the contract of poicy, enter amount	
7,777	
e Type of contract (1) X individual policies (2) group deferred annuity	
(3) Some (Specify)	
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here	7
Standard Vitti Unallocated Funds (Do not include portions of these contracts maintained in contracts	
(2) immediate naticipation guarantee	
(3) guaranteed investment (4) other (specify below)	
▶	
b Balance at the end of the previous year C Additions: (1) Contributions deposited the previous year	
- Contributions deposited during the year	
(2) Dividends and credits	
(3) Interest credited during the year	
(4) Transferred from separate account	
(5) Other (specify below)	
(6) Total additions	
(6) Total additions d Total of balance and additions (add. bland 199)	
d Total of balance and additions (add b and c)6))	
(1) Disbursed from fund to pay benefits or purchase annuities during year	
(2) Administration charge made by carrier	
(3) Transferred to separate account	
(4) Other (specify below)	
(5) Total deductions .	
Balance at the end of the current year (subtract e (5) from d).	······································



	Schedule A (Form 5500) 2001	Page 4	
	Part III Welfare Benefit Contract Information		Official Use Only
	If more than one contract covers the same group of employees of the sa employee organization(s), the information may be combined for reporting as a unit. Where individual contracts are provided, the entire group of suctreated as a unit for purposes on this report.	me employer(s) or members of the purposes if such contracts are exp ch individual contracts with each ca	same perience-rated arrier may be
7	Benefit and contract type (check all applicable boxes)		
	A Health (other than dontal asset)	רז	
	P Temporary disability (secretary)	C Vision	d Life Insurance
	Ston loss flores de bustil i	9 Supplemental unemployme	ent h Prescription drug
	m Other (specify)	k PPO contract	I Indemnity contra
8	Experience-rated contracts		
J	The state of the s	i l	
	(2) Increase (decrease) in amount due but unpaid (3) Increase (decrease) in unparped promiting account.		
	(3) Increase (decrease) in unearned premium reserve		
	(4) Earned ((1) + (2) - (3))		
þ	The good (1) Clarita Paid		
	(2) morease (decrease) in claim reserves	·	
	(a) meeting claims (add (1) and (2))		
	Cy		
С	Activation of premium, (1) Retention charges (on an accrual basis)	17	v. 1: -: 1 - 1.00 - 1.00 - 1.00 - 1.00 - 1.00 - 1.00 - 1.00 - 1.00 - 1.00 - 1.00 - 1.00 - 1.00 - 1.00 - 1.00 -
	(A) Commissions	ļ.'	
	(b) Administrative service or other fees		
	(C) Other specific acquisition costs		
	(D) Other expenses		
	(E) Taxes		
	(F) Charges for risks or other contingencies		
	(G) Other retention charges	i i i i i i i i i i i i i i i i i i i	
	(F) Folds retention		
	(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or	Credited)	
ď	or policyholder reserves at end of year: (1) Amount held to provide benefits after	retirement	
	(2) Cially reserves		······································
a	(a) Other reserves		
<u>e</u>	12) A remode the returned due. (Do not include amount entered in c(2))		· · · · · · · · · · · · · · · · · · ·
	The state of the s		
a b	Total premiums or subscription charges paid to carrier	***************************************	rest actions a resulting 1, 2,177,177
.,	in the carrier, service, or other organization incurred any specific costs in connection and		
	or retention of the contract or policy, other than reported in Part I, item 2 above, report at Specify nature of costs.	mount	
	openity matura of costs		



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SCHEDULE I (Form 5500)

Department of the Finastry fixternal Revenue Service Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Financial Information -- Small Plan

This schedule is required to be filed under Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

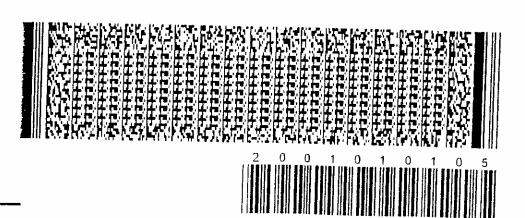
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		D	Empl	oyer Ide	ntifica	tion Number
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ing of	the plan year. Yo	u may	also c	omplete	Schedu	ile I if you
te Scr	neaute H if report	ng as	a large	plan or	DFE.	
	misorance contra	els du ct that s) or s	ring the guarar separat	e plan ye ntees dur ely maint	ar. Cor ing this	nbine the
rest d	foliar.			,		-no(s) and
	(a) Beginnir	ig of Y	'ear		(b)	End of Year
1a				5		8,879,198
1b						- 3,3,2,130
1 c	1.0	, 34	4,62	5		8,879,198
	(a) Am	ount				(b) Total
ĺ				ris (Lander Brown	b) Total
(1)		4	7289.	5		
(2)						
(3)						
b						
C	-1	, 938	3,322	2		
d						-1,465,427
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k followed the control of the contro	lowing categories ue of the plan's in	, chec	k "Yes In a co	and en	ler the d	
111	- specific except	O(15 U	escribe	in the	instruct	ions.
· · · · ·			X	1	A	nount
			X	 		
	ind crof an increst (1) (2) (3) b c d d e f q h i i i confide e of the value e of the confidence of th	ind changes in net assort an including any trust(rest dollar. (a) Beginnii (a) Am (b) C	ind changes in net assets du of an insurance contract that ian including any trust(s) or s rest dollar. (a) Beginning of Y 1a 10, 34 1b 1c 10, 34 (a) Amount (1) 4 (2) (3) b c -1, 938 d e f g h i i c the following categories, check he value of the plan's interest e of the specific exceptions d Yes	ind changes in net assets during the of an insurance contract that guaranterist dollar. (a) Beginning of Year 10, 344, 62 10, 344, 62 (a) Amount (1) 47289 (2) (3) b C -1, 938, 323 d e f g h i i K the following categories, check "Yes he value of the plan's interest in a cite of the specific exceptions describe a cite of the specific exceptions described as a cite of the specific exception as a cite of t	ind changes in net assets during the plan ye of an insurance contract that guarantees during the plan ye of an insurance contract that guarantees during the plan ye of an insurance contract that guarantees during the plan ye of an insurance contract that guarantees during the plan ye of the plan ye of the plan ye of the plan's interest in a commingle of the specific exceptions described in the land that ye is not a commingle of the specific exceptions described in the land that ye is not a commingle of the specific exceptions described in the land that ye is not a commingle of the specific exceptions described in the land that ye is not a commingle of the specific exceptions described in the land that ye is not a commingle of the specific exceptions described in the land that ye is not a commingle of the specific exceptions described in the land that ye is not a commingle of the specific exceptions described in the land that ye is not a commingle of the specific exceptions described in the land that ye is not a commingle of the specific exceptions described in the land that ye is not a commingle of the specific exceptions described in the land that ye is not a commingle of the specific exceptions described in the land that ye is not a comming that ye	(a) Beginning of Year (b) II Id 10,344,625 Ib



Case 2:08-cv-01567-GEB -MCA Document 57-14 Filed 09/17/10 Page 12 of 62 PageID:

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	Schedure I (Form 5500) 2001	<u> </u>	<u>je 2</u>		·)therat this enty
			Yes	No	Amount
Зc	Real estate (other than employer real property)	Зс	1	X	Amogni
d	Employer securities	3d		$\overline{\mathbf{R}}$	
е	Participant loans	3e	-	X	
f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3 q		Х	
Pa	rt II Transactions During Plan Year		<u> </u>	ļ	
4	During the plan year:		Yes	No	Amount
a	Did the employer fail to transmit to the plan any participant contributions within the maximum	1111	994.40		
	time period described in 29 CFR 2510.3-1027 (See instructions)	4a		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the		7.7		萨斯尔克尔克尔克尔克
	close of the plan year or classified during the year as uncollectible? Disregard participant	13.83			
	loans secured by the participants' account balance	4b		X	
C	Were any leases to which the plan was a party in default or classified during the year as	35	11.1116	334	
	uncollectible?	4c		Х	Marketine of a self-base self-bill a self-bill a
d	Did the plan engage in any nonexempt transaction with any party-in-interest?	4d	<u> </u>	Х	
e	Was the plan covered by a fidelity bond?	4e	Х		350000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was	117.45	:11V(4): -		
	caused by fraud or dishonesty?	4f		Х	
q	Did the plan hold any assets whose current value was neither readily determinable on an		and a		
-	established market nor set by an independent third party appraiser?	4g		Х	
h	Did the plan receive any noncash contributions whose value was neither readily	4646			
	determinable on an established market nor set by an independent third party appraiser?	4h		Х	
i	Did the plan at any time hold 20% or more of its assets in any single security, debt,	100			
	mortgage, parcel of real estate, or partnership/joint venture interest?	4i		Х	
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to				
	another plan, or brought under the control of the PBGC?	4i	GLOSSON	X	
k	Are you claiming a waiver of the annual examination and report of an independent qualified				
	public accountant (IQPA) under 29 CFR 2520.104-46? If no, attach the IQPA's report. (See			d Sec.	
	instructions for conditions to be eligible for waiver.)	. 4k	Х		
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year	? If yes, ent	er the	amour	nt of any plan assets that
	reverted to the employer this year	X No		ount	
5b	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify t	he plai	n(s) to	which assets or Habilities
	were transferred. (See instructions.)				
	5b(1) Name of plan(s) 5b(2)	EIN(s)			5b(3) PN(s)

	<u> </u>



Case 2:08-cv-01567-GEB -MCA Document 57-14 Filed 09/17/10 Page 13 of 62 PageID: 1737

SCHEDULE P (FORM 5500)

Department of the Treasury

Internal Revenue Service

Annual Return of Fiduciary of Employee Benefit Trust

This schedule may be filed to satisfy the requirements under section 6033(a) for an annual information return from every section 401(a) organization exempt from tax under section 501(a).

Filing this form will start the running of the statute of limitations under section 6501(a) for any trust described in section 401(a) that is exempt from tax under section 501(a).

File as an attachment to Form 5500 or 5500-EZ.

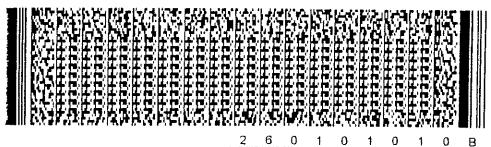
Official Use Only

OMB No. 1210-0110

2001

This Form is Open to Public Inspection.

For trust calendar year 2001 or fiscal year beginning	and ending
1a Name of trustee or custodian	
MARIO CRISCITO, M.D.	
b Number, street, and room or suite no. (If a P.O. box, see the instruct	ons for Form 5500 or 5500-EZ.)
769 NORTHFIELD AVENUE	
C City or town, state, and ZIP code	
WEST ORANGE NJ 07052	
2a Name of trust DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MON	EY PURCHASE PLAN
	323990
3 Name of plan if different from name of trust	
4 Have you furnished the participating employee benefit plan(s) with the	,
to be reported by the plan(s)?	
5 Enter the plan sponsor's employer identification number as shown on or 5500-EZ	
Under penalties of perjury, I declare that I have examined this schedule, an complete.	
Signature of fiduciary	Date ►
or the Paperwork Reduction Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-EZ.	v4.1 Schedule P (Form 5500) 200





SCHEDULE R (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

Official Use Unity

OMB No 1210-0110

Pension Benefit Guaranty Cor	noithed		File as an Altac	:hment to Form !	550 0 .				blia lasas	
For calendar year 2001 o	r fiscal plan	year beginning			and ending			1 111	blic Inspe	ction,
A Name of plan						В	Three-	diail		····
DIAGNOSTIC & C	LINICA	L CARDIOLOGY, P	A. MONEY	PURCHASE P	LAN]	plan nu	3	.	002
C Plan sponsor's name								yer Identifi	cation N	
DIAGNOSTIC & C	LINICA	L CARDIOLOGY, P	. A .				,,,,		323990	
Part I Distrib	utions				·····					
All references to di	istribution	s relate only to payment	s of benefits du	ring the plan yea	or.	**********				
Total value of distrib	utions paid	in property other than in ca	ish or the forms o	of property specific	ed			1		
in the instructions							1	s		
2 Enter the EIN(s) of p	payor(s) who	paid benefits on behalf of	I the plan to partic	cipants or benefici	iaries			Andria (Service) Andria (Service)	7,000000000000000000000000000000000000	
during the year (if m	ore than two	o, enter EINs of the two pay	yors who paid the	greatest dollar ar	mounts					lla ver Mela appeted
of benefits).	 						100000			ği birə
		and stock bonus plans,								
3 Number of participar	nts (living or	deceased) whose benefits	s were distributed	l in a single sum, :	during					
the plan year						<i>.</i>	3		***************************************	
Part II Fundin	g Inform	ation(If the plan is not s	ubject to the mini	mum funding requ	uirements of :	section	412 of	the Internal	Revenue	
Code or E	RISA section	n 302, skip this Part)								
4 Is the plan administra	ator making	an election under Code se	ection 412(c)(8) o	r ERISA section 3	302(c)(8)? .			Yes	X No	N/A
If the plan is a defir									·	
		ng standard for a prior yea								
plan year, see instruc	ctions, and	enter the date of the ruling	letter granting the	e waiver		. •	Month	Da	yY	ear
If you completed the	ne 5, comp	lete lines 3, 9, and 10 of	Schedule B and	do not complete	e the remain	nder of	this so	hedule.		
Ca. Enter the minimum re							6a	\$		472895
		the employer to the plan for		* * * * * * * * * * * * *			6b	\$		472895
		om the amount in line 6a. E	Enter the result (e	enter a minus sign	to the left					
of a negative amount	•						6c	\$		0
		ot complete the remaind							<u></u>	
approval for the chan	ar cost metr	nod was made for this plan	year pursuant to	a revenue proced	dure providing	g autom	atic	\Box		
On not complete lin	ge ur a cias	s ruling letter, does the pla	un sponsor or plar	n administrator ag	ree with the d	change:	?. ,	· · [Yes	∐ No	∐ N/A
8 Is the employer electi	na ta como	olan is a multiemployer p ute minimum funding for th	oran or a pian wi	ith 100 or lewer p	participants	during	; the pr	rior plan ye	ar (see in	st.).
provided in Code sec	ing to contip	11) and ERISA section 30:	iis pian year usini	g the transitional r	rule			П		
Part III Amend	ments	TT/ and EINISA Section 30.	2(0)(11)1	<u></u>	*******	<u> </u>		Yes	No	N/A
		n plan, were any amendme	ents adopted durin	ng this plan year t						 _
increased the value o								П.,	Π	
······································		ce and OMB Control Nu		neterations for I				. Yes	No	
or raperwork reduction	on Act NOU	ce and OMB COMBO NG	inners, see me i	instructions for I	rom 5500.	V4	1.1 S	chedule R	(Form 550	JO) 2001
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SCHEDULE T (Form 5500)

Department of the Treasury Internal Revenue Service

Qualified Pension Plan Coverage Information

This form is required to be filed under section 6058(a) of the

Internal Revenue Code (the Code).

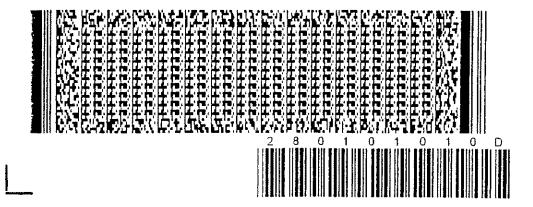
Official Use Only OMB No 1210-0110

2001

This Form is Open to Public Inspection.

Schedule T (Form 5500) 2001

Internal Revenue Service File as an attachment to Form 5500.							Public	c Inspection.	
For cal	endar year 200	it or fiscal plan	year beginning			and ending			
	me of plan NOSTIC &	CLINICAL	CARDIOLOGY,	P.A. MONI	EY PURCHAS	SE PLAN	В	Three-digit	002
			on line 2a of Form 5500 CARDIOLOGY,		···		D	Employer Identi	fication Number
Note: 1	f the plan is ma	aintained by:					!		
Mor eac	e than one emp h employer (se	oloyer and bene e the instruction	ifits employees who ar n for line 1),	e not collectively	/-bargained emp	loyees, a separate	Schedule	T may be required	for
• An eac	employer that o h QSLOB (see	perates qualifie the instruction	d separate lines of but for line 2),	siness (QSLOB	s) under Code s	ection 414(r), a se	eparate Sch	nedule T may be rea	quired for
			provide coverage infol an one employer, ente				nployees of	an employer partic	ipating
1a N	ame of particip	ating employer				,	1b Em	ployer identificati	on number
2 If	the employer n	naintaining the I	plan operates QSLOB	is, enter the follo	wing information	n:	<u></u>		
a T	he number of C	SLOBs that th	e employer operates is	3					
bТ	he number of s	uch QSLOBs t	hat have employees b	enefiting under t	this plan is				
			nimum coverage requi						. Yes No
d ir	the entry on lin	e 2b is two or n	nore and line 2c is "No	o," identify the Q	SLOB to which t	the coverage infor	mation give	n on line 3 or 4 rela	ites.
			fore each statement th complete the rest of			oloyer. Also see in:	structions.		
a	The employe	er employs only	highly compensated e	mployees (HCE	s).				
ь	No HCEs be	enefited under th	he plan at anytime duri	ing the plan year	r.				
c	The plan ber	nefits only collec	ctively-bargained empl	loyees.					
d [ຸ including lea	sed employe e s	cludable nonhighly con and self-employed inc	dividuals.				ctions 414(b), (c), a	and (m)),
e	The plan is t	reated as satisf	ying the minimum cov	erage requireme	ents under Code	section 410(b)(6)	(C).		



For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Case 2:08-cv-01567-GEB -MCA Document 57-14 Filed 09/17/10 Page 16 of 62 PageID: 1740

	 Schedule T (Form 5500) 2001 		Page 2				
					Offi	cial Use Only	
4	Enter the date the plan year hegan for which coverage data	is being submitted.	Month U	1	Day 01	Year 2	001
a	Did any leased employees perform services for the employee	r at any time during the p	lan year?			Yes	⊠ No
b	In testing whether the plan satisfies the coverage and nondis	scrimination tests of Cod	e sections 410(b) and 401(a	1)(4),			
	does the employer aggregate plans?					Yes	X No
С	Complete the following:					Ч	فحا
	(1) Total number of employees of the employer (as defined	in Code section 414(b),	(c), and (m)), including				
	leased employees and self-employed individuals			c(1)	24	
	(2) Number of excludable employees as defined in IRS regi	ulations (see instructions	s)			Ú	
	(3) Number of nonexcludable employees. (Subtract line 4c)	(2) from line 4c(1))		c(3)	24	
	(4) Number of nonexcludable employees (line 4c(3)) who are	re HCEs		c(4	}	12	
	(5) Number of nonexcludable employees (line 4c(3)) who be	enefit under the plan 👑		c(5)	23	
	(6) Number of benefiting nonexcludable employees (line 4c	(5)) who are HCEs		c(6	}	12	
đ	Enter the plan's ratio percentage and, if applicable, identify t	he disaggregated part of	the plan to which the				
	information on lines 4c and 4d pertains (see instructions)	>		<u>d</u>		91.7	13
e	Identify any disaggregated part of the plan and enter the rati	o percentage or exceptio	n (see instructions).				·
	Disaggregated part: Ratio	Percentage:	Exception:				
	(1)						
	(2)						
	(3)						

(1) X the ratio percentage test

average benefit lest



This plan satisfies the coverage requirements on the basis of (check one):

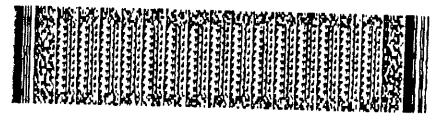
•	i i	V-01567-GFG FNE/Cerpsim Employee PPS 1741	nyf(6	ecury	Si aye	5 17 01	File W		S Only
Department of the Interior Revenue S	STWC6	► For Paperwork Reduction Act Notice, see inst				1 (2)			•
File before the		filler, plan administrator, or plan sponsor (see instructions)			ying Num Instruction	iber—Chec s).	к аррисави	a box and	Lenter
normat due		NOSTIC & CLINICAL CARDIOLOGY, P.A.				sdraun noal			
cate of the Form 5500,		, street, and room or suite no. (If a P.O. box, see instructions.)		i a most d Instructio	onteran E ons	IN. All othe -23239	r mers, see		
5500 €Z, Or		NORTHFIELD AVENUE	1						
5330 (see instructions)	,	own, state, and ZIP code		Social se	curity nun	nber(see S	pecific Inst	ructions)
		ORANGE, NJ 07052	ļ'	-					
a X Form The approximate on line You mu b Form Complete DIAGNOST P.A. MON 3 State in	m 5500 confication and filed 1 is no nest attach m 5330 (ete the four EY PUE	Disc same/blok	ove) if: for wheed after To File Type of	(1) box nich this er the d e): f plan Welfare	1a is characters ue date(see (check) Fringe	necked, (2 for the place instruction number 0 in 0 in incomplement of the place in incomplement of the	ested, ans listed ons) Plan Month 2 12	below. year el Day 31	nding Year 2001
authorized to pr				Date ➤		JUL _			
Signature 🕨	1			Date >) 1:. —		·	· · · · · · · · · · · · · · · · · · ·
Notice to Applicant	│ 🖂 Th	Completed by the IRS if line 1b is checked ▼ sis application for extension to file Form 5330 IS approved to the line of the state of the line of the	o the o	date sh at was	own on granted	line 1, if	line 1b is nsion.)	check	ed. (You
	I⊟ты	ne date entered on line 1 is more than the 6-month maximum	time ali	owed f	or Form	5330. Thi	s applica	ion is a	pproved
To Be	to	.,		• • • • • • • • • • • • • • • • • • •	(Yaı	u must at	tach an	approv	ed copy
Completed	of	this form to each Form 5330 that was granted an extens	ion.)						
by the IRS if Line 1b		ne application for an extension for Form 5330 is not approve turn. (A 10-day grace period is not granted.)	d, bed	ause it	was file	d after th	e normal	due da	te of the
ls Checked		nis application for an extension for Form 5330 is not approve	ed, bed	:ause					
CHECKEU	I	The application was not signed.							
	1	No reason was given on this application or the reason was	not a	cceptab	ole.				
	1	No payment was attached for the tax due on Form 5330.							
		Other >							
		ou must attach a copy of this form to each return you file	e that	is gran	ted a gi	race peri	od.)		
		(Dute) (Director)		· · · · · · · · · · · · · · · · · · ·		····	_ Ву:		
Applicants to	r extens	ion of Form 5330: Complete if you want this Form 5558 return	ned to	an addi	ess other	er than th	e address	shown	above.
дрисана п	Name								
Please			- 14 9000 14 9000 14 9000						
Print	Numb	er, street, and room or suite no. (If a P.O. box, see instructions.)							
or									
Туре	City o	r town, state, and ZIP code							

EXHIBIT 73

					!	
1					840	374 0074
Form 5500	Annual Return/Rono	e of Easts.		. Mas	. 401	VZ 0001
Department of the Treesury	Annual Return/Repo	it of Employ	yee Benerii	t Pian	CIME	i U so Only i 1210 - 0110
Attend Revenue Service	Retirement Income Security Act of	riuer seccions 194 if 1974 (PRISA) on	and 4068 of the	Employee		1210 - OCH
Department of Lister Pension and Walters Senation	4067(b), and 4658(a) of the	t Internal Revenue	e Code Abe Code	o, see, (e),	20	002
A derrote a free hands	Complete att	eniries in accorda	e come (ii se com	<i>"</i>		
Pension Benefit Quarenty Corporation	the instruct	ons to the Form (600,]	This Fort Public	n is Open to Inspection
Partie Annual Repo	rt identification Information			<u></u>		
For the calendar plan year 2003	or flecal plan year beginning		and endin	ю.	·	
	a multiemployer plan;			-employer plan;	Of	
(2)	 i single-employer plan (other than a multiple-employer plan); 	ı	(4) = DFE (s			
	montparentiproper posity					
B This return/report is: (1)	the first return/report filed for the ple					
. , ,	an amended return/report;	et;		eturatreport filed		
C If the plan is a collectively-barg	mined plan, check here		14) LJ a Short pl	on year return/re	port (less that	n 12 months), _c
D. If filling under an extension of the	me or the DFVC program, check box an	It attach monicael for	formation (see a fee			
Parelle Basic Plan in	ormation enter at requested info	mation.	TOTTINGUE (3 DE 1175	(LICOOLE)		· · · · · · · · · · · · · · · · · · ·
13 Name of plan			1	b Three-dipil		
DIAGNOSTIC & CLINICA	L CARDIOLOGY,		['	by unuper	7 /DM1	002
P.A. MONEY PURCHASE	PLAN		1	C Effective de	<u> </u>	- · · · · ·
			7	34/01/1976	e or heat filler	., cany, yr.j
2+ Branch				7-13-11		The latest and
(Address should include room	ress (employer, if for a single-employer p	(nak	2	b Employer Ide	entification No	mber (EIN)
DIAGNOSTIC & CLINICA	L CARDIOLOGY		L		22-	2323990
CARDIOLOGY, P.A.			20	C Sponsors le		
				·		31-9442
			20	d Business co	de (see insku	-
769 NORTHFIELD AVENU	E		roc	No. of Concession, Name of Street, or other party of the Concession, Name of Street, or other pa		621111
			1		2000	多级海域
			122		STERNING.	
EST ORANGE			23	200		看到了大
	N	J 07052				医传统经验
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	others and forth in the measurement, I declare that the it is being fitted electronically, and to the best of my				Materianis and a	Rachments as well
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	9 /0///2	Wanta apra	~~ ~			
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TOTAL MARIE	10	Type or print	t name of individu	al signing as pla	n administrato	×
ERE /// 100 /	\$0\(\(\sigma\)\(MARIO CRISC	מא חיידד			
Signature of employer/plan spor		Tuesday and an artist and artist				
or Paperwork Reduction Act Not	ice and OMB Control Numbers, see I	he instructions to	· Form State		w DFE	
/		the integractions to	r rome bagg,	√5. 0	Form :	5500 (2002)
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Form 5500 (2007)		849374 9074
Page 2	<u></u>	V91.02,UUUZ
3a Plan administrator's name and address (If same as plan aponsor, enter "Same") SAME 3b Administrator's name and address (If same as plan aponsor, enter "Same")	rator e	EIN
JC Administ	lalot,#	telephone number
4. If the name and/or £iN of the nian someon has been discussed in	1.13	对于
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:		p EIN
a Sporsor's name		C PN
5 Preparer Information (optional) a Name (including firm page 4 applicable)		C FR
Preparer information (optional) A Name (including firm name, if applicable) and address AMERICAN PENSION CORPORATION		D EIN
1375 PLAINFIELD AVENUE		22-2141197
		C Telephone number
WATCHUNG NJ 07069	İ	908-757-5151
Total number of participents at the beginning of the plan year Number of participents as of the sed of the sed.	6	33
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d) a Active participants		THE PROPERTY OF THE
D Retired or separated participants receiving benefits Other retered or separated participants.	7a	30
and a separate paracipants encided to future benefits	7b	0
G Subtotal, Add lines 7a, 7b, and 7c	<u> </u>	
or beceased participants whose beneficianes are receiving or are entitled to receive benefits	<u>7</u> d	32 8
1 your woo mate 10 bild 16	7e	32
complete this items	**	
Number of perticipants that terminated employment during the plan year with accrued benefits that were less than	70	32
11111111111111111111111111111111111111	7h	
		_
8 Delivers provided (index the plan (complete the and the second-state)	<i>T</i> i	0
2 Pension benefits (check this box if the plen provides pension benefits and enter the applicable pension feature codes from Characteristics Codes printed in the instructions): 2		
b Wettere benefits (check this box if the plan provides wetters benefit and		
Characteristics Codes printed in the instructions):	fine Lis	t of Plan
98 Plan funding arrangement (check all that apply) 9b Plan hands arrangement (check all that apply)	,	J []
[1] Insurance Insurance	ipply)	
(2) Code section 41 2(I) instrance contracts		
(3) X Trust (2) Code section 412(i) ansurance co	ntracts	•
(4) General assets of the sponsor		
		1

Form 5500 (2002) 10 Schedules attached (Check all applicable hower and unborn indicated)	8403740074 087.02.0003 04-4 Use Ship
Schedules attached (Check all applicable boxes and, where indicated, entities Pension Benefit Schedules (1)	b Financial Schedules (1) H (Financial Information) (2) X I (Financial Information - Small Plan) (3) X 2 A (Insurance Information) (4) C (Service Provider Information) (5) U (DFE/Participating Plan Information) (6) G (Financial Transaction Schedules) (7) X 1 p (Trust Fiduciary Information)



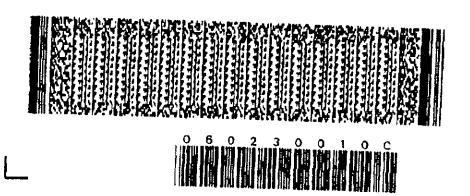




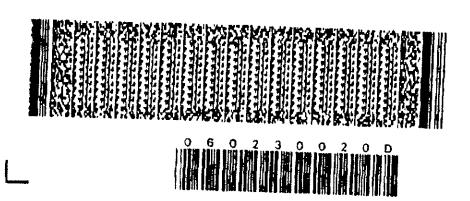
P O. BOX 7043 LAWRENCE, KS 66044-7043

Form 55.	58	Application for Extensi	^n _1	T:					
(Flev. June 20	. ,	To File Certain Employee	Diam Diam	Ont.	₽		300	(11.0015
Department of the Internal Revenue	Service	Fee Description Control Contro	ridil	retu	rns		X		77
Fie before the	Neme o	For Paperwork Reduction Act Notice, set (fler, plan administrator, or plan sporeor (see instructions)	instruc	tions on	back.		F	Witness	#48.
normal due date of the	01740	NOSTIC & CLINICAL CARRYONS	i F	for's bla	ndifying M m insuruct	unber-Che	ck epipic	to aid	and enter
Form 5500,	,	TO BONG NO. IN A P.O. bys and instrument	Q	Emoto	wate internif				
5500-EZ, or 5330 (see	703	MONTHRIETD AUGUSTS	ĺ	instru			- 4 M M S, E	es Spec	ille Ille
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1 I reque	at an exte	ORANGE, NJ 07052				umber (see 5	pecilie ir	retrue No	ne)
		month rise (O 146 (C	theck ap	propria	te box(e:	s)).			···
signed on line You mu	and filed of its no most attach in 5330 (n	r 5500-EZ (no more than 2½ months), as automatically approved to the date shown on line 1 (on or before the normal due date of Form 5500 or 5500 ore than 2½ months after the normal due date. as copy of this Form 5558 to each Form 5500 and 5508-EZ or more than 8 months). Payment amount attached is owing for the plan(s) account in the chapter account of the plan(s) accounts the chapter account in the chapter acc	Z filed at	ter the :	Am date		uested, Ins lister		
·····		owing for the plan(s) covered by this application (see Ho	w To F	le):	130	a mizhinelk	onsj		
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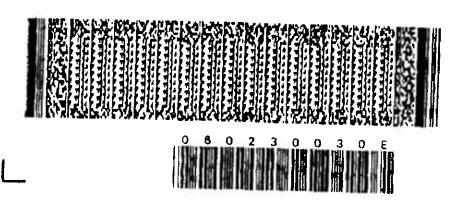
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(Harma)	Perense Service		SAME LEGISTS	ment income Security Act of 1974				
Laurente and Meth		P Insurance	File as an attachment to Form 6800. Insurance companies are required to provide this information.				2002	
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A Name of clan				and end	<u> </u>			oute anapaction
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		wn on line 2a of Form 5500 AL CARDIOLOGY, P.			to	Employer		002 Ication Number
Partiti Int	ormation (Opposition leaves	Α.	t Coverage, Fees, and Co			- CIMI	22-2323990
VEW YORK LI	<u> </u>	4			-		·	
(p) EIN	(c) NAIC	(d) Contract or identification number	(a)	Approximate number of persons		Poli	EV Ot CO	nfract year
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Insurance less :	and commission	or malel to account to the	other person	ha. Enler the total fees and total con	1	01/01/200	2	12/31/2002
brokers and other	r persons indi-	idually in descending order of t	tie amount	ha. Enler the total fees and total con paid in the items on the following pa	geri Geri	sions below a	nd list a	gents,
		of of commissions paid	To	als				
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Schedule A (Form 5500) 2002	Page 2	04037400 087.02 A
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	Schedule A (Form 5500) 2002	Page 3	840374 0074 087, 02, 0006
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e Type of		YOUR deferred annuity	
	other (specify)	•	
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e Deduction	Henrica min sociations (sod pland c.)		
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Batance at	the end of the current year (subtract e(5) from d).	**********************	
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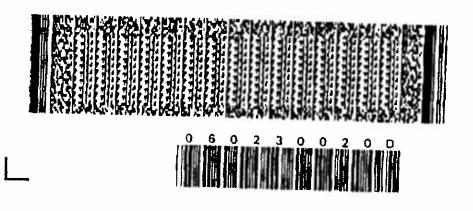
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Or carendar year A Name of plan	2002 or fiscal pl	en year beginning		≥nd endi	30		Pu	blic inspection
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		(a)	Name of in	Surance carrier			****	
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(b) EIN	(c) NAIC code	identification number 4024790 s paid to agents, brokers and o tually in descending order of b	Covered	at end of policy or contract year i. Enter the total fees and total con iid in the items on the following pa		(f) Fro 1/01/20	90	(g) To
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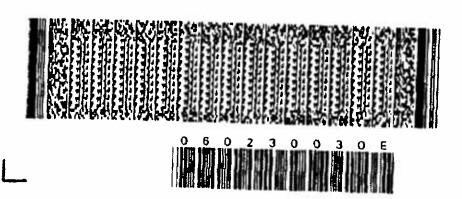




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35.63CH A (FORM \$5.00)	707	Page 2	087.02.00
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7 Ge	If more than one contract covers the sam employee organization(s), the information as a unit. Where individual contracts are p irrested as a unit for purposes on this repo melit and contract type (check all applicable boxes)	e group of employees of the sa may be combined for reporting trovided, the entire group of suc it.	me employer(s) or members of th purposes if such contracts are ex th individual contracts with each o	e same perience-rated arrier may be
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3 Yolal b if the or refe	rperience-rated contracts: premiums or subscription charges paid to carrier carrier, service, or other organization incurred any s intion of the contract or policy, other than reported i fly nature of costs.	Charife couls in a second		

SCHEDULE | (Form 5500)

Department of Labor Pension and Walters Benefits Alforetic steen

Financial Information - Small Plan

This schedule is required to be filed under Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). 8403740074 987.02.0012

OMB No. 1210-0110

2002

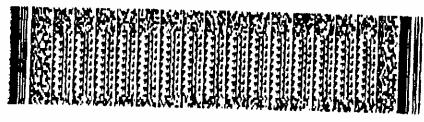
File as an attachment to Form 6500. Peneran Benefit Custonly Corporate This Form is Open to Public Inspection. For calendar year 2002 or fiscal plan year beginning and ending A Name of plan DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN Three-digit C Plan sponsor's name as shown on line 2s of Form 5500 plan number 002 DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. D Employer Identification Number Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you 22-2323990 are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or OFE Small Plan Financial Information Report below the current value of assets and liebbilles, income, expenses, transfers and changes in net assets during the pien year. Combine the value of plan assets held in more than one trust. On not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date, Include all income and expenses of the plan including any trust(s) or separately maintained (und(s) and any payments/receipts to/from insurance corners. Round off amounts to the nearest dollar. Plan Assets and Liabilities: (a) Boginning of Year a Total plan assets (b) End of Year 12 0879196 8117946 b Total plan liabilities 16 Net plen assets (subtract line 1b from line 1s) 8879199 10 8117946 Income, Expenses, and Transfers for this Plan Year: (a) Amount Contributions received or receivable (b) Total Za(1) 619049 (2) Participants 24(2) (3) Others (including rollovers) 2a(3) Noncash contributions 2b Other income -1318968 2¢ Total income (add tines 2s(1), 2s(2), 2s(3), 2b, and 2c) 2d Benefits paid (including direct rollovers) 20 Corrective distributions (see instructions) 21 Cartain deamed distributions of participant loans (see instructions) 29 h Other expenses 2h Total expenses (add lines 2e, 2f, 2g, and 2h) 21 Net income (foss) (subtract line 2i from line 2d) 2i -761252 Transfers to (from) the pian (see instructions) Specific Assets: if the plan heid assets at engine during the plan year in any of the forming categories, check "les" and enter the current value of any assets remaining in the plan as of the plan year. Affocuse the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described as the instructions.

3 Partnership/Joint venture interests Temployer real property Temployer real property Temployer real property

For Paperwork Reduction Act Notice and DMB Control Mumbers, see the instructions for Form 6590.

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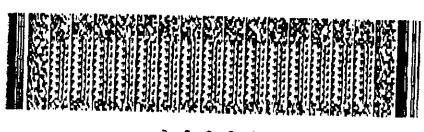
Schedule I (Form 6500) 2002

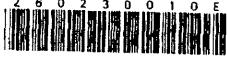




Schedule I (Form 5500) 2002		930	<u></u>			8403740(087.02 ()74 1013
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Real estate (other than employer real property)			Yes	Ho		Amount	
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Perticipant loans		30		X			
Loans (other than to participants)		30		X			
langible personal property		3f 3a	-	X T			
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Ouring the plan year:			Yes	Vo			
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Fiducian Committee Control 2010, 3-1027 (Size instructions and DOL's Voluntary			觀點	24		面似的技	
Were any loans by the plan or fixed income obligations due the plan in default as of		44		X			2 10
close of the plan year or classified during the year as uncollectible? Disregard partic	the	退量	£3,44	2010	原設集	建装	CHIEF TO SERVICE STREET
control age of the bendinistral accutal papers				132			
Were any leases to which the plan was a party in default or classified during the year	****	4b					
	ir as	No.	250			战争性态	
Util the plan engage in any nonexempt transaction with any neck-in-interest?		4c 4d					
vvas the plan covered by a fidelity bond?			x l	* [3.6	***
Did the plan have a lose, whether or not reimbursed by the plan's fidelity bond, that w	199		Â	2	77.7	J\$	0000
Agree by (1900 of Citionesta)		41	200 ()	22.1		347 5-24	4.1
Did the plan hold any assets whose current value was neither readily determinable or	n en		1 12 2	20	in the proper	100 C 100 C 100 C 100 C	
Consideration (Figure 1 not set by an independent third nade approximant		40	>		See 2 18		7.2
Did the plan receive any moncesh contributions whose value was neither readily differminable on an actabilities and actabilit			1613			1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	D.P
determinable on an established market nor set by an independent third party appraise Did the plan at any time hold 20% or more of its essets in any single security, debt,	H?	4h	X	1		to the term of the contract of	** D. ***
mortgage, parcel of real estate, or partnership/joint venture interest?		是表示	100	4	4.54	Water Sec.	200
Were all the plan assets either distributed to participents or beneficiaries, transferred		41	X				
where the property is a condition of the party of the par		233	机的	200		au le Fre	100
Are you distining a waiver of the annual exercination and report of an industrial		41	X				新疆
Prices accountant (RUPA) under 29 CFR 2526 (St. 46-46-5) the setting the contract of the contr	107700	透り			7.53		
- Table 10 Table 20 Only 10		Ale)	-	48	3	Section	輟
ries a resolution to terminate the plan been adopted during the plan year or any prior of	Ian year? If ye	B. ector i	he erec	-		-	200
everted to the employer this year	Yes 🛭	No A	punonun Punonun	UTHE THE R	пурши	essets (hat	
if during this plan year, any assets or liabilities were transferred from this plan to anoth were transferred. (See instructions.)	er plan(s), ide	ntify the	plan(s)	o whic	h assets	or implifica	
5b(1) Name of dan(s)						AL HANDENING	
	5b(2) EIN(u)				5b(3) P	Nies
	~						-

		1
•		340374 0074
SCHEDULE P (FORM 5500)	Annual Return of Fiduciary	107.02.0014
(FORM 3500)	of Employee Benefit Trisi	OMB No. 1210-0110
	This schedule may be filed to satisfy the requirements under section 6033(a) for an annual information return from every section 481(a) organization exempt from tax under section 661(a). Filing this form will start the running of the statute of limitations under section 6581(a) for any tried described.	2002
0	that it exempt from tax under	This Fam. 1 C
Department of the Tressury Internal Revenue Service	section 601(a). File as an attachment to Form 6500 or 5500 EZ.	This Form is Open to Public Inspection,
6		
1a Name of trustee or o	O2 or fiscal year beginning and ending	
MARIO CRISCITO,		,
b Number, street, and	room or suite no. (If a P.O. box, see the instructions for Form 5500 or 5500-EZ.)	
769 NORTHFIELD	·	
C. City or fown, state, a		
WEST ORANGE	NJ 07052	
2a Name of trust DIAGNOSTIC & CL	INICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	
b Trust's employer iden	Hifteation number 22-2323990	
	and from name of breat	
		
4 Have you hereshed th		
to be reported by the	ie participating employee benefit plan(a) with the trust financial information required plan(s)?	
	and the second s	······ 🛛 Yes 🔲 No
Enter the plan aponto	r's employer identification number as shown on Form 5500	
o/ 5500-EZ		22-2323990
GN Signature of feduciary	declaration is have examined this schedule, and to the best of my knowledge and belief it is true, co	rrect, and complete.
	Date */0/15/2	}
or the Paperwork Reduc	tion Notice and OMB Control Humbers, v5.0	/
ee the instructions for Fe	orm 5500 or \$500-EZ.	chedule P (Form 6500) 2002





SCHED	ULE R
(Form	55001

Congresses of the Treesury tricemal Revenue Service Department of Labor Televice and Workson Revenue

Partition Sanité Currenty Cornection

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

Fife as an Altachment to Form 6500.

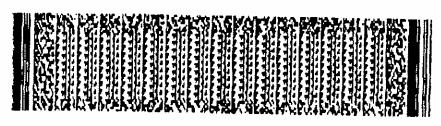
840374 0074 087.02.0015

OMB No 1210-0110

2002

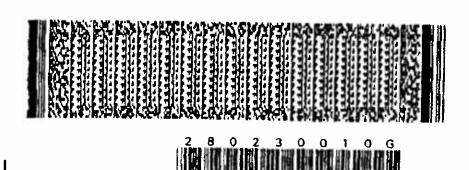
This form is Open to Public Inspection

calender year 2002 or fiscul plan year beginning					Inspection.
Name of plan					,
AGNOSTIC & CLINICAL CARDIOLOGY, P.A. HONEY PURCHASE PLAN	8		_		00:
Plan sponsor's name as shown on line 2s of Form 5500	n				
AGNOSTIC & CLINICAL CARDIOLOGY, P.A.	15	Empto	учт юзел	NIICALI	on Mumber 22-2323996
itti Distributions					22-232399
All references to distributions relate only to payments of benefits during the state of the stat					
Total value of distributions paid in property gitter than in cash or the force of several		1	1		
in the instructions		1.1	5		
Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to padicipants as benefits in		FUNDS	S CONTRACTOR		
charing the year (if more than two, enter EINs of the two names who need the greatest define		0.00	35.15	333	第二人
of benefits). 22-2323990		1			医
Profit-sharing plans, ESOPs, and slock bonus riens, shin line 1		1	33.5		34年1
Number of participants (fiving or deceased) whose benefits were distributed in a shade were		100		100	A STATE OF THE STA
the plan year		175000	Care.		15 法法国的政治
Funding information (If the plan is not subject to the minimum funding and		131			
Code or ERISA section 302 skin this Part)	#4CDO	41201	and suffer	III Rev	enue
Is the plan administrator making an election under Code section 412(cVR) or FRISA section 302(cVR)			77	- 1	, ,
if the plan is a defined benefit plan, go to line 7.		• • • • •	. U Y	H5 [_	JNo UNIA
if a waiver of the minimum funding standard for a prior year is being amortized in this					
pian year, see instructions, and enter the date of the ruling letter granting the weiger					
If you completed line 6, complete lines 3, 8, and 10 of Schedule 8 and do not complete the complete the	 	MODIN		7 8 y	Year
	MARK O				619049
Enter the amount contributed by the employer to the plan for this clan year					619049
Subtract the amount in line 65 from the amount in line 6s. Enter the result (enter a minus soon to the less		₹	<u> </u>		013043
of a negative amount)		ا مم آ			0
If you completed line &c, do not complete the remainder of this schedule.			<u> </u>		
If a change in actuarist cost method was made for this plan year pursuant to a reverse world to one billion				•	
approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the	BUKOIT	MING	Πv.	. 🗂	
Mile Amendments	Junge	f			No INA
I this is a defined benefit pension plan, were any amandments adopted during this plan year that					
ncreased the value of benefits? (see instructions)			n.	П	
Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5608.	· · · · · · · · · · · · · · · · · · ·	50 9			No
	,			(1 67	IN -4441 TORY
	Plan sponsor's name as shown on line 2s of Form 5500 AGNOSTIC & CLINICAL CARDIOLOGY, P.A. Professors to distributions relate only to payments of benefits during the plan year. Total value of distributions paid in properly other than in cash or the forms of properly specified in the instructions Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). 22-2323990 Profit-sharing plans, ESOPs, and stock borrus plans, skip line 3. Number of participants (fiving or deceased) whose benefits were distributed in a single sum, during the plan year Funding Information (if the plan is not subject to the minimum funding requirements of Code or ERISA assison 302, skip this Part). Is the plan administrator making an election under Code section 412(c)(8) or ERISA section 302(c)(8)? If the plan is a defined benefit plan, go to line 7. If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruring letter granting the weiver. If you completed time 6, complete times 3, 8, and 10 of Schedule 8 and do not complete the ramain Enter the amount in line 6b from the amount in the 6a. Enter the result (enter a minus sign to the left of a negative amount). If you completed line 6c, do not complete the remainder of this schedule. If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing appoint to the change or a class ruling letter granting or pursuant to a revenue procedure providing pages to the change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing pages to the change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing pages.	Plan sponsor's name as shown on line 2s of Form 5500 AGNOSTIC & CLINICAL CARDIOLOGY, P.A. BY references to distributions All references to distributions relate only to payments of benefits during the plan year. Total value of distributions paid in property other than in cash or the forms of property specified in the instructions Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). 22-232.3990 Profit-sharting plans, ESOPs, and stock borrus plans, skip line 3. Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year Funding Information(if the plan is not subject to the minimum funding requirements of section Code or ERISA section 302, skip this Part) Is the plan administrator making an election under Code section 412(c)(8) or ERISA section 302(c)(8)? If the plan is a defined benefit plan, go to line 7, If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the weiver plan year, see instructions, and enter the date of the ruling letter granting the weiver ### You completed line 6, complete times 3, 8, and 10 of Schedule 8 and do not complete the remainder of Enter the amount in time 6b from the amount in time 6b. Enter the result (enter a minus sign to the left of a negative amount) 1 you completed line 6c, do not complete the remainder of this schedule. 6 a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing sulor person to the change or a class ruling letter, does the plan sconsor or plan administration with the change approval for the change or a class ruling letter, does the plan sconsor or plan administration with the change approval for the change of benefits? (see instructions)	Plan sponsor's name as shown on line 2s of Form 5500 AGNOSTIC & CLINICAL CARDIOLOGY, P.A. Distributions All references to distributions paid in property other than in cash or the forms of property specified in the instructions Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). 22-232.3990 Profit-sharing plans, ESOPs, and stock borrus plans, skip line 3. Number of participants (tiving or deceased) whose benefits were distributed in a single sum, during the plan year. Funding Information(if the plan is not subject to the minimum funding requirements of section 412 of Gode or ERISA section 302, skip this Pay). Is the plan administrator making an election under Code section 412(c)(8) or ERISA section 302(c)(8)? If the plan is a defined benefit plan, go to line 7. If a weiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the weiver. Another fixes the amount contributed by the employer to the plan for this plan year. Enter the amount contributed by the employer to the plan for this plan year. Subtract the amount in line 6b from the amount in line 6e. Enter the result (enter a minus sign to the left of a change in actuantal cost method was made for this plan year. If you completed line 6c, do not complete the remainder of this schedule. Amendments Amendments Amendments Amendments Amendments Amendments Amendments Plas is a defined benefit pension plan, were any amendments adopted during this plan year that minus approach to the change or a class niting lefter, does the plan year pursuant to a revenue procedure providing submartic approval for the change or a class niting lefter, does the plan year pursuant to a revenue procedure providing submartic approval for the change or a class niting lefter. So the plan year pursuant to a	Plan sponsor's name as shown on line 2s of Form 5500 AGNOSTIC & CLINICAL CARDIOLOGY, P.A. Distributions All references to distributions relate only to payments of benefits during the plan year. Total value of distributions paid in property other than in cash or the forms of property specified in the instructions Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during they are (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). 22-2323990 Profit-sharing plans, ESOPs, and stock bonrus plans, skip line 3. Number of participants (tiving or decessed) whose benefits were distributed in a single sum, during the plan year Funding Information(if the plan is not subject to the minimum funding requirements of section 412 of the interrogent year and entering plans, go to line 7. If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the value. If you completed line 6, complete tines 3, 9, and 10 of Schedule 5 and do not complete the remainder of this schedule. Enter the amount in line 6b from the amount in line 6e. Enter the result (enter a minus sign to the left of a negative amount) If you completed line 6c, do not complete the remainder of this schedule. 4 a change in actuatal cost method was mede for this plan year pursuant to a revenue procedure providing automatic open of the change or a class name later. One of the plan sconsor or plan estimates agree with the change? Year perfective results of benefits? (see instructions) Papervoris Reduction Act Notics and OMER Control benefits and do not complete that controlled person plan, were any amendments adopted during this plan year that	Plan sponsor's name as shown on line 2e of Form 5500 AGNOSTIC & CLINICAL CARDIOLOGY, P.A. All references to distributions relate only to payments of benefits during the plan year. Total value of distributions paid in property other than in cash or the forms of property specified in the instructions Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaties during the year (if more than two, enter EINs of the two payors who paid the greatest dotar amounts of benefits). 22-2323990 Profit-sharring plans, ESOPs, and stock bonus plans, skip line 3. Number of participants (tiving or deceased) whose benefits were distributed in a single sum, during the plan year. Funding Information (if the plan is not subject to the minimum funding requirements of section 412 of the internal Rev. Gode or ERISA section 302, skid this Part). Is the plan administrator making an election under Code section 412(c)(8) or ERISA section 302(c)(8)? If the plan is a defined benefit plan, go to line 7. If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the weiver. Another of the minimum required contribution for this plan year Enter the amount contributed by the employer to the plan for this plan year Enter the amount in line 85 from the amount in time 6a. Enter the result (enter a minus sign to the left of a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing sutomatic proposal for the change or a class noting lefts, does the plan sponsor or plan administrator providing sutomatic providing entered the change of a class noting lefts, does the plan sponsor or plan administrator providing entered corrected the value of benefits? (see instructions) If you completed benefit pension plan, were any amendments adopted during this plan year that correspond to the change or a class noting lefts.





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	Ouglified Pension Dis- C-		C COLO	•
SCHEDULE T	Qualified Pension Plan Coverage Informa	tion	OMB No 1210	0-0110
(Form 5500)	This form is required to be filled under section 6058(e) of the internal Revenue Code (the Code).		200	02
Considerant of the Frenchis course Resemble Service	File as an allachment to Form 6609.		This Form	is Open to
For calendar year 2002 or t	fiscal plan year beginning and ending		, appe 11)	Speciality
A Name of plan	INICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	B Three	٠ ١	00:
C. Plan sponsor's name a	is shown on line 2s of Form 5500 INICAL CARDIOLOGY, P.A.		oyer (dentifica	
				and the second s
in a plan maintained b 18 Name of participating	ng filed to provide coverage information regarding the noncollectively bargained employ by more than one employer, enter the name and EIN of the participating employer employer		Noyer participate	
1a Name of participating	y more than one employer, enter the name and EIN of the participating employer employer			
Name of participating If the employer maintail	y more than one employer, enter the name and EIN of the participating employer			
1a Name of participating If the employer mainta The number of QSLOI The number of such O	employer employer thin one employer, enter the name and EIN of the participating employer employer thin ing the pran operates OSLOBs, enter the following information: the the employer operates is SSLOBs that have employees benefiting under this plan is	Employer	identification r	
13 Name of participating 2 If the employer mainta 3 The number of QSLOI D Does the employer app	employer ining the pran operates OSLOBs, enter the following information: Stathet the employer operates is 2SLOBs that have employees benefiting under this plan is ply the minimum coverage requirements to this plan on an employer-wide rather than a	OSLOB basis	identification r	number
13 Name of participating 2 If the employer mainta 3 The number of QSLOI D Does the employer app	my more than one employer, enter the name and EIN of the participating employer employer. 1b ining the plan operates OSLOBs, enter the following information: 8s that the employer operates is	OSLOB basis	identification r	number
2 If the employer mainta 2 The number of OSLO Does the employer app of If the entry on line 2b is Exceptions — Check the	employer ining the pran operates OSLOBs, enter the following information: Stathet the employer operates is 2SLOBs that have employees benefiting under this plan is ply the minimum coverage requirements to this plan on an employer-wide rather than a	OSLOB basis given on fini	identification r	number
2 If the employer mainta 2 If the employer mainta 3 The number of QSLOI D The number of such O C Does the employer app of if the entry on line 2b is Exceptions — Check th If you check any box a The employer emp	employer ining the plan operates OSLOBs, enter the following information: the ining the plan operates OSLOBs, enter the following information: the title employer operates is SSLOBs that have employees benefiting under this plan is ply the minimum coverage requirements to this plan on an employer-wide rather than a is two or more and line 2c is "No," identify the QSLOB to which the coverage information the box before each statement that describes the plan or the employer. Also see instruct is, do not complete the nest of this Schedule, vioys only highly compensated employees (HCEs).	OSLOB basis given on fini	identification r	number
In a pain maintained b Name of participating If the employer maintai The number of SSLOI Different of such C C Does the employer app If the entry on line 2b is Exceptions — Check th If you check any box The employer emp No HCEs benealer	employer ining the plan operates OSLOBs, enter the following information: the time amployer operates is SLOBs that have employers benefiting under this plan is ply the minimum coverage requirements to this plan on an employer-wide rather than a is two or more and line 2c is "No," identify the QSLOB to which the coverage information the box before each statement that describes the plan or the employer. Also see instruct to do not complete the rest of this Schedule, thoys only highly compensated employees (HCEs), do under the plan at anytime during the plan year.	OSLOB basis given on fini	identification r	number
In a pain maintained b Name of participating If the employer maintail The number of SUCHO Does the employer app If the entry on line 2b is Exceptions — Check th If you check any box The employer emp No HCEs benealted The plan benefits of	employer ining the plan operates OSLOBs, enter the following information: distinct the employer operates is SSLOBs that have employees benefiting under this plan is ply the minimum coverage requirements to this plan on an employer-wide rather than a is two or more and line 2c is "No," identify the QSLOB to which the coverage information the box before each statement that describes the plan or the employer. Also see instruct is, do not complete the rest of this Schedule, idoys only highly compensated employees (HCEs), id under the plan at anytime during the plan year, only collectively-bergained employees.	OSLOB basin given on find Uons.	identification r	Yes No
2 If the employer mainta 2 The number of QSLOI D The number of Such O C Does the employer app of If the entry on line 2b is Exceptions — Check th If you check any box a The employer emp b No HCEs benealter C The plan benefits of	employer ining the plan operates OSLOBs, enter the following information: distinct the employer operates is SSLOBs that have employees benefiting under this plan is ply the minimum coverage requirements to this plan on an employer-wide rather than a is two or more and line 2c is "No," identify the QSLOB to which the coverage information the box before each statement that describes the plan or the employer. Also see instruct is, do not complete the rest of this Schedule, idoys only highly compensated employees (HCEs), id under the plan at anytime during the plan year, only collectively-bergained employees.	OSLOB basin given on find Uons.	identification r	Yes No
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-		Page 2	8403 987	4 0074
4.	Enter the date the plan year began for which coverage data is being submitted.		O∰AI ∪ee	
a	Old strip interest employees perform services for the employees at any lines above to	Month 01	Day 01 Ye	
Ь	In testing whether the plan satisfies the coverage and nondiscrimination tests of Code sections 410(b) does the employer aggregate plans? Complete the following:			Yes X A
C			· 📵 ·	res AlNa
	 (1) Total number of employees of the employer (as defined in Code section 414(b), (c), and (m)), includessed employees and self-employee individuals. (2) Number of excludable employees as defined in IDS and defined in IDS. 			
			(1)	32
				δ
			[3]	32
			(4)	13
				36
đ		<u> c</u>	6)	13
Ġ	Identify any disappregated part of the plan and enter the ratio percentage or exception (see instructions)		1	89.5 %
	Disaggregated part: Ratio Percentage: Exception:		···-	
	(3)	•		
		•		
τ_	This plan satisfies the coverage requirements on the basis of (check one): (1) 🕅 the ratio perce	ntage test	(2) T #versoe bene	St tues





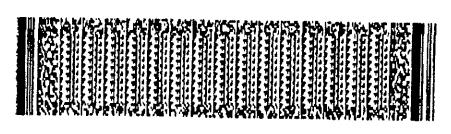
EXHIBIT 74

5500			84043654 147.06.0001
Form 5500	Annual Return/Report of Employe This form is required to be filed under sections 104 a	e Benefit Plan	Official Use Only OMB Nos 1210 - Ot to
Internal Revenue Service Department of Labor	Transfer income Security Act of 1974 (ERISA) at	of sections 4047/av	1210 - 0080
Employee Benefits Security Administration	6967(b), and 6968(a) of the internal Revenue (Complete all entries in accordan	Code (the Code).	2003
Pension Bereit Guaranty Corperates	the instructions to the Form 44	ce with	This Form is Open to Public inspection.
	port identification information 1993 or fiscal plan year beginning		. come dispection.
A This return/report is for:	(1) a multiemployer plan;	3) a multiple employer plan:	
	(2) Planingsometries after technique	4) a DFE (specify)	
B This return/report is: C If the plan is a collectively-t D If filing under an extension	(1) the first return/report filed for the plan; (2) an amended return/report; (4) pargained plan, chack here of time or the DFVC program, check box and allech required into		if for the plan;
1a Name of plan	mir of friedricht — enter an requested information,		
DIAGNOSTIC 4 CLINI P.A. MONEY PURCHAS	CAL CARDIOLOGY,	15 Three-digit plan numbe	r(PN) ▶ 002
THE CONDITION OF THE PARTY	C PLAN		le of plan (mo., day, yr.)
2a Pho special sales		0.70171976	WITH THE THE THE
(ADGT#\$\$ Should include re	address (employer, if for a single-employer plan) pom or suite no)	25 Employer ld	entification Number (EIN)
DIAGNOSTIC & CLINI CARDIOLOGY, P.A.	CAL	2c Sponsor's te	22-2323990 iephone number
			973-731-9442
769 NORTHFIELD AVE	NUE.	20 Suames co	de (see instructions) 621111
VEST ORANGE	W.I. 0708.2		
aution: A penalty for the late of Under ponalties of pertury and other	r incomplete fifing of this return/report will be assessed unless rea	sonable cause le established,	3.000mm19.000mm26.000mm
Signature of epiployer/pla	n sponsor/DFE MARIO CRISCI	TO, H.D. TO, M.D. TO, M.D.	n administrator
m s-aparasora (paguetion Act i	Notice and OMB Control Numbers, see the instructions for i	Form \$500, v6.1	Form 5500 (2003)
		PENSAU A00-631-6000	PLAINTIFF'S EXHIBIT CRISCITO 17
·············	0 2 0 3 6 5 0	ОН	

	34043654 147.06.0002
Form \$500 (2003)	US
14 Plan administrator's name and address (if same as rice species and address if	Official Use Only
SAME 3b Administration	mtor's EIN
3c Administra	alor's telephone number
	men a carabatoria (Maliforni
4. If the name and/or EIN of the pten sponsor has changed since the last return/report filed for this pten, enter the name,	b ein
EIN and the plan number from the last return/report below: 3 Sponsor's name	O EM
d sharen strenge	C PN
5 Preparer information (optional) a Name (including firm name, if applicable) and address	
AMERICAN PENSION CORPORATION	P EIN
1375 PLAINFIELD AVENUE	22-2141197
19:2 INCHAILEDS VACUOR	C Telephone number
WATCHUNG NJ 07069	000 202 4000
6 Total number of participants at the beginning of the plan year	908-757-5151
7 Number of participants as of the end of the ptan year (watere plans complete only lines 7a. 7b. 7c. and 7d.	
d Active participants	7a 36
China patient as an arrival and arrival and arrival ar	7b 0
d Subtotal Add lines 7a, 7b, and 7c	7¢ 4
e Decassed participants whose beneficiaries are receiving or are artified to receive benefits	7d 42 7e 0
T Total Add lines 7d and 7e	71 42
Number of participants with account belances as of the end of the plan year (only defined contribution plans complete this item)	
h Number of participants that terminated employment during the plan year with secrued benefits that were less than	<u>7a</u> 42
Too at temperature of the second of the seco	7h 0
native and a second of the sec	······································
participants required to be reported on a Schedule SSA (Form 5600) 8 Benefits provided under the plan (complete Ba and 86 as applicable)	71 0
a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature and the	m the I let of Man
Consequences codes busined at the initial codes. 2C 2R BE) (
b Weltare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from Characteristics Codes printed in the instructions):	the List of Plan
9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that	
(1) Consurance	m-(my)
(2) Code section 412(f) insurance contracts (2) Code section 412(f) insurance or	niracis
(3) X Trust	
[5] I Guillatt Essets of the operator	
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	Form 5500 (2003)				 Pa	21 _3		84043654 147.06.0003
10	Schedules affected (Charle all applicable home and utilized	4	 		 			Official Use Orly
a	Schedules attached (Check all applicable boxes and, where indicated, an Pension Benefit Schedules (1) X R (Retrement Plan Information) (2) X 1 T (Qualified Pension Plan Coverage Information) If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year (3) B (Actualial Information) (4) E (ESOP Annual Information) (5) SSA (Separated Vested Participant Information)	b		attach tal Sci		(Financial (Financial (Insurancial (Service F (OFE/Part	informal informal informal rovider (ticipating	tion — Small Plan) Itlon) Information) Plan Information) Itlon Schedules)

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Form 55	558	Application for Extensio	n 06	T:		840	1385		
(Flèv, June 2	-	To File Certain Employee f	olan I	anne Retur	ne.	14	(A) E	184 S 541	5-0212
Department at 'n/e/mit Reven	a Seven	For Paperwork Reduction Ant Making				03	File V	Ville IC	RS Only
File before to	Name (The state of the s	[Fi	or's Iden	ifring Na	mber-Chec			
normal due dete of the	Numbe	NOSTIC & CLINICAL CARDIOLOGY, P.A.							
Form 5500, 5500-FZ, or	769 N	PROBLEM STREET, and room or suite no. of a P.O. box, see instructions.) 9 NORTHFIELD AVENUE Instructions.							king bon in:
5330 (see instructions)	City or	lown, stare, and ZIP code		>		-2323994			OR
		TORANGE, NJ 07052		Social s	acurity nu	mber (see Sp	moitic inc	itraction	4
1 Izmogu	iest an ext	ension of time until 18 / 15 / 2004 to file (ci	heck app	propriet	box(es) .			
a 🕅 Fo	orm 5500 d	or 5500-EZ (no more than 2½ months).			·	•			
ine a signer on line	ipplication d and filed e 1 is no n	is autometically approved to the date shown on line 1 (c) on or before the normal due date of Form 5500 or 5500- nore than 2½ months after the normal due date.	CE 101 M	WACH UN	a extent	nou is usón	ested, o	rad (3) t	the date
b 🗍 Fo	om 5330 4	a copy of this Form 5558 to each Form 5500 and 5500-EZ no more than 6 months). Psyment amount attached is	filed aft	er the d	ue date	for the plea	s ilsted	below.	
2 Comp	lete the fo	flowing for the plants) covered by this application (see Ho	. To 00		(se	instruction	n s)		
		Plan name/filer	1	of plan	Irback)		-		
DIACNOST	CIC & CCI	INICAL CARDIOLOGY,		Weitare		Plan number	Month	Day	Year
P.A. MONE	Y PURCE	ASE PLAN	x			0 0 2			
						0; 0: 2	12	31	2003
			├			<u> </u>			
3 State in		ny you need the extension (if line 1b is checked)				; : ;	ĺ		
Under cenetic authorized to possible to Applicant To Be Completed by the IRS if Line 1b is Checked	To Be C This must to of the return This The This N	completed by the IRS if Sne to be checked V application for extension to file Form 5330 IS approved at attach an approved copy of this form to each Form that the 6-month maximum his form to each Form 5330 that was granted an extension for form 5330 is not approved. A 10-day grace period is not granted.) application for an extension for Form 5330 is not approved application for an extension for Form 5330 is not approved application was not signed. It is reason was given on this application or the reason was to payment was attached for the tax the on Form 5330 to payment was attached for the tax the on Form 5330.	to the disaso that time site sion.) ad, becaute, becaute	Date in a state and a state and a state and a state at war grant and a state at war a state at a st	e7/99/j wn on the granted Form 5 (Yourse filed	ne 1, if line an extension attached att	on.) on.) oplication	checked on is appoproved	J. (You proved d copy
policants for	(You		of the di	ue date grante	of the r d a grad	eturn, which re period.)	:		
T	Name	of Form 5330: Complete if you want this Form 5658 return	ed to an	addres	a other	han the ad	trees si	is awar	DOVE,
Please					200		S 244 2		10 Vá.
Print or	Number, s	treet, and room or suite no. (If a P.O. box, see instructions.)							
Туре	City or tow	wn, state, and ZIP code		(4) E					

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Consentinent of	5500)	1	This schedul	e is require	d to be filed under section 184 o	(the	<u> </u>	OMI	9 No. 1210-0110
Himmer Reve	Ne Service	İ			ent Income Security Act of 1974. attachment to Form 6506.				2003
Employee Senelia Sec	or Lobert Softy Administration	14 00			we required to provide this inform	tia-		74.7-	
Peneron Beneta Guer				ol meurous	ERISA section 103(s)(2)	(SUC)		Pu	Form is Open to iblic Inspection.
For calendar plan yea A Name of plan	2003 or fig.	al stan yea	r beginning		and en	ting			
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C Plan sponsor's na DIAGNOSTIC & Infor	CLINIC	AL CARE	IOLOGY, P.A		Coverage, Fees, and C	D	Employer k		Ication Number 22-2323990
1 Coverage;			[a]	Name of i	NATION CONTINUES				
(b) EIN	(c) NAIC	(d)	Contract or ication number	(=)	Approximate number of persons		Pofic	y or co	nitract year
		- NORM	Cation NUMBER	covere	d at end of policy or contract year		(I) From		(g) To
		P81025	- •	1		,	01/01/200		12/31/2003
Incurance feet and other p	i commission persons indiv	s paid to a idually in de	gents, brokers and o	ther person	is. Enter the total fees and total coald in the items on the following			d Het i	pgenta,
					iajs	-9-1	-,,		
	Total amour	t of commi	ssions paid		To	al feet	ppid / amoun	t	
or Paperwork Remi	tion Act No.	Hea and O	WP Cookers to	0	e instructions for Form 6586.			•••	0



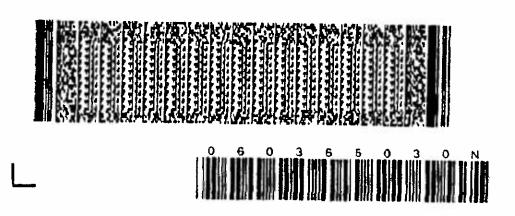


	(a) Name and addr.	Page 2	Official Use Only
	persons to whom	commissions or less were paid	
(b) Amount of commissions paid		Fees paid	(f Organi
	(c) Amount	(d) Purpose	CO
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		The state of the s	MEDITORY C
	(a) Name and addre	es of the agents, brokers or other commissions or fees were paid	
	(a) Name and addre	as of the scenis, brokers or other	
(b) Amount of commissions paid	(a) Name and addre paraona to whom	as of the scenis, brokers or other	(•
(b) Amount of	(a) Name and addre	es of the agents, brokers or other commissions or fees were paid	Organia cod
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(b) Amount of commissions paid	(a) Name and address persons to whom	Fees paid (d) Purpose so of the agents, brokers or other	(e) Organiz cod
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(b) Amount of commissions paid	(a) Name and address persons to whom	Fees paid (d) Purpose so of the agents, brokers or other	(e) Organia cod





Γ	Schedule A (Form 5500) 2003 Page 3	84043654 147.08.0006
	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each currier may purposes of this report.	Official Use Only
3	Current value of plan's interest under this contract in the general account at year end	
4	Current value of plan's interest under this contract in separate accounts at year and	
5	Contracts With Allocated Funds	
a	State the besis of premium rates DON FILE WITH THE DEPT. OF INS.	
b		42000
¢	Premiums due but unpaid at the end of the year	
d	If the certier, service, or other organization incurred any specific costs in consection with the acquisition	
	or retention of the contract or policy, enter amount	J
	Specify nature of costs N/A	
•	Type of contract (1) 1 individual policies (2) group deferred annuity	•
	(3) U other (specify)	_
		• 🛘
6	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other (specify below)	
ь	Balance at the end of the previous year	
_		West Constitution of the last
•	(2) Owdends and credits	- 6亿层发现现代的
	(3) Interest credited during the year	
	(4) Transferred from separate account	
	(5) Other (specify below)	建筑是是
	(6) Total additions	学 公公公司的基本的证明
d	Total of between most addition of the found of the	
•	Deductions:	THE RESERVE OF THE PARTY OF THE
	(1) Disbursed from fund to pay benefits or purchase annuities during year	医医验验检验验验验
	(2) Administration charge made by carrier	
	(3) Transferred to separate account	
	(4) Other (specify below)	自然學習過過過過過
		经 经年轻经济公司
	(5) Total deductions	THE PERSON NAMED IN COLUMN
1_	Batence at the end of the current year (subtract e (5) from d)	
	V0	i.1



	Schedule A (Form 5500) 2003 Page 4	840436 54 147.06,0007
B	Welfare Benefit Contract Information	Cfficial Use Only
	If more than one contract covers the same group of amployees of the same employer(s) or members of the employee organization(s), the information may be combined for reporting purposes if such contracts are ex- sise unit. Where individual contracts are provided, the entire group of such individual contracts with each of treated as a unit for purposes on this report.	
7	Benefit and contract type (check all applicable boxes)	
	a Health (other than dentel or vision) b Dental c Vision	.0
	e Temporary disability (accident and sickness) Long-term disability g Supplemental unemployer	d Life insurance
	Stop less (large deductible) HMO contract K PPO contract	1-4
	m L Other (specify) >	I 📙 indemnity contract
8_	Experience-rated contracts	提供なるの意思なるのというでは
đ	Premiums: (1) Amount received	
	(2) Increase (decrease) in amount due but unpaid (3) Increase (decrease) in unearned premium reserve	是领域的思想是
	(4) Earned ((1) + (2) - (3))	
b	Benafit charges; (1) Claims paid	
	(2) Increase (decrease) in claim reserves	
	(3) Incurred claims (add (1) and (2))	
	(4) Claims charged	
Ç	Remeinder of premium: (1) Retention charges (on an accrual basis)	PARTICIPATION STATE OF THE PARTY OF THE PART
	(A) Commissions	
	(B) Administrative service or other fees	
	(C) Other specific acquisition costs	不及在各种的基本的
	(D) Other expenses (E) Taxes	
	(F) Charges for risks or other contingencies	第20年第三日海中的巴
	(G) Other retention charges	
	(H) Total retention	and the state of t
	(2) Ovidends or retroactive rate refunds. (These amounts were paid in cash, or credited.)	
đ	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	
	(2) Claim reserves	
	(3) Other receives	
<u>.e.</u>	Dividends or retroactive rate refunds due. (Oo not include amount entered in c(2).)	
•	Nonexperience-rated contracts:	
b I	Total premiums or subscription charges paid to carrier	
	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, Item 2 above, report amount	
	Specify nature of costs	
		
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	Ad'1	
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1	Representation of the property	
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SCHEDULE I (Form 5500)

Financial Information -- Small Plan

This achedule is required to be filed under Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 6606.

Officeal Use Only OMB No. 1210-0110

2003

This Form is Open Pension Bungit Gueranty Corporation to Public Inspection. For calendar year 2003 or flecal plan year beginning and ending A Name of plan B Three-digit DIAGNOSTIC & CLINICAL CARDIOLOGY, MONEY PURCHA P.A. Phin number 002 C. Plan sponsor's name as shown on tine 2s of Form 5500 D Employer Identification Number DIAGNOSTIC & CLINICAL CARDIOLOGY, 22-2323990

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 perticipant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date, include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance centers. Round off amounts to the nearest dollar

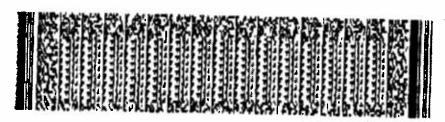
Plan Assets and Liabilities:	16.2	Isl Beginning of Year	
Total plan assets		8117042	(b) End of Year
			8462930
Not plan assets (subtract line 1b from tine 1a)			G.
			8462930
	2-15-27-20	(a) Amount	(b) Total
	20/41	720018	
(2) Participanta	24/21	,,20013	MARKET LEVEL TO THE
(1) Others (including rollovers)	20121		
Noncash contributions	21-		
		-316003	
Total income (add lines 2a(1), 2s(2), 2s(3), 2b, and 2c)	- 3	SERVICE PARKS OF STREET	The state of the s
Benefits paid (including direct rollovers)	20 10	AND DESCRIPTION OF THE PROPERTY OF	103115
Corrective distributions (see instructions)	24	10131	
Certain deemed distributions of participant loans (see instructions)			
		12000	
Fatal annua annua de del Henri de Las de Las de Las de Las de Las de Las de Las de Las de Las de Las de Las de		42000	
del income flores facilities of a 10	- 103	2000年1900年1900年1900年1900年1900年1900年1900年	58131
ransfere to (from) the plan (see instructions)	21 1		344984
	Total plan assets Total plan assets (Subtract fine 1b from kine 1a) Income, Expanses, and Transfers for this Plan Year: Contributions received or receivable (1) Employers (2) Participants (3) Others (including relovers) Noncash contributions Other income Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c) Senettis paid (including direct rollovers) Corrective distributions (see instructions) Certain deemed distributions of participant loans (see instructions) Other expanses Total expenses (add lines 2e, 2l, 2g, and 2h) Interiorne (loas) (subtract time 2l from line 2d)	Total plan assets Total plan assets Total plan assets (subtract line 1b from line 1a) Its income, Expanses, and Transfers for this Plan Years Contributions received or receivable (1) Employers (2) Participants (3) Others (including relovers) Noncash contributions Other income Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c) Senettis paid (including direct rollovers) Corrective distributions (see instructions) Certain deemed distributions of participant loans (see instructions) Other expanses Total expenses (add lines 2e, 2l, 2g, and 2h) In its uncome (loas) (subtract time 2i from line 2d) Transfers in from the size from line 2d)	Total plan assets Total plan assets Total plan sebilities Net plan assets (subtract fine 1b from line 1a) Income, Expanses, and Transfers for this Plan Year: Contributions received or receivable (1) Employers (2) Participants (3) Others (including rollovers) Noncash contributions Other (income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c) Benefits paid (including direct rollovers) Corrective distributions (see instructions) Corrective distributions (see instructions) Corrective distributions (see instructions) Cortain deemed distributions of participant loans (see instructions) Cortain deemed distributions (see instructions) Cortain deemed (add lines 2e, 2f, 2g, and 2h) Instruction (see instructions) (subtract time 2i from line 2d) Conserve to (from) the circ (from) the 2d from line 2d)

Specific Assets: If the plan held assets at anytime during the plan year in any of the second cetegories, check as and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plans on a line-by-line besis unless the trust meets one of the specific exceptions described in the instructions.

Yes No Amount 2 Partnership/joint venture interests X 3a Employer real property Ŧ 36

For Paperwork Reduction Act Notice and OMB Control Numbers, sea the instructions for Form 5608.

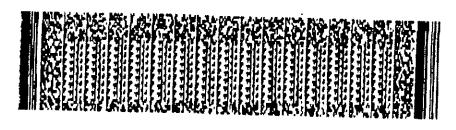
Schedule ! (Form 6500) 2003





Γ	Schedule I (Form 5500) 2003		Р	1200 2		81	4043654 47.06.0009	•
				, ,	1	(Official Use Only	
3¢	Real estate (other than employer real property)		30	Ye	No X	 	Amount	
đ	Employer securities		30	_	+ x	 		
e	Participant loans		34		X			
-	Loans (other than to participents)		34		X			
1	Tangible personal property		30	ıL.	Х		·····	
3	During the plan year:	·····				·		
4a	Did the employer fail to transmit to the plan any participant contributions within the ti		700	Yes	No		Amount	_
	period described in 29 CFR 2510.3-102? (See instructions and DOE's Voluntary	THE STATE OF	50		134		200	
	Fiduciary Correction Program)		42	-	ΙX	CELLE.	ESSUATE FILE	4
þ	Were any loans by the plan or fixed income obligations due the plan in default as of t	ne		BEE.	17.3	Contract of	SE CAME	M.
	close of the plan year or classified during the year as uncollectible? Disregard partici	pant				3333		
c	loans secured by the perticipants' account balance		4b		X			-
_	Were any bases to which the plan was a party in default or classified during the year uncollectible?	##	16.5	E M	建 基度	12.00		7
đ	Were there any nonexampt transactions with any party-in-interest? (Do not include	• • • • • •	4c	es and	X	NAME OF TAX		-
	transactions reported on line 4a.)		4d	E AND	X	MADE	REAL PROPERTY.	
e	Was the plan covered by a fidelity bond?		40	1 x			35000	_
ť	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that w	44	790		MALE	SANTE OF	DOMESTIC STATE	853
	caused by fraud or dishonesty?		41	1	X	STATE STATE	CONTRACTOR SOLL	100
g	Old the plan hold any assets whose current value was nother readily determinable on	an .	240	ER	C. 432	No.	经基础的	34
h	established market nor set by an independent third party appraiser? Did the plan receive any noncash contributions whose value was neither readily		49		X			_
**	determinable on an established market nor set by an independent third party appraise		200	623		21.66	CERTAIN OF THE	2
i	Old the plan at any time hold 20% or more of its essets in any single security debt	MT ?	7300	PNY	-			-
	mortgage, parcel of real estate, or partnership/joint venture interest?		4	-	X	40000	1000年至末於位置	93
j	Were all the plan assets either distributed to participants or beneficiaries, transferred	to	988	50	Mark!	Mark E.S.		F87
L.	another plan, or brought under the control of the PBGC?		44		X			ä
_	Are you claiming a waiver of the annual examination and report of an independent qua public accountant (IQPA) under 29 CFR 2520.104-467 if no, attach the IQPA's report	lified	56	20		150	(h	d
	2520,104-50 statement. (See instructions on waiver eligibility and conditions.)			BAR		2545		a.
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior prevented to the employer this wear	dag ven	CO If your and	^				
	and the same and an indication when he had a first the same and the sa	1 V	DCT at.					
5D	If during this plan year, any assets or liabilities were transferred from this plan to anothwere transferred. (See instructions.)	er plan	(9), identify t	he play	x(a) (c)	hich assess	or tiphilities	
	Mere transferred. (See instructions.) 5b(1) Name of plan(s)			•				
	and a hamile	5b(2)	EHN(s)				5b(3) PN(a)	
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		84043654 147.06.0010
SCHEDULE P (FORM 5500)	Annual Return of Fiduciary of Employee Benefit Trust This schedule may be filed to satisfy the requirements under section \$603(a) for an	Official Use Only OMB No. 1210-0110
	under section 481(a) organization enempt from tax under section 681(a). Filling this form will start the remotes of the start to a literature of the start to a	2003
Ownertment of the Freezewy Incomal Revenue Service	659 (a) for any trust described in section 481(a) that is exempt from tax under section 681(a), File as an attachment to Form 5600 or 5500 EZ.	This Form is Open to Public Inspection.
For trust calendar year 20	03 or fiscal year beginning	
769 NORTHFIELD C City or town, state, as WEST ORANGE 2a Name of trust	room or suite no. (If a P.O. box, see the instructions for Form 5500 or 5500-EZ.) AVENUE	
b Trust's employer iden 3 Name of plan if differen	nfication number 22-2323990	
5 Enter the plan sponso or 5500-EZ	e perfloipating employee benefit plan(s) with the trust financial information required plan(s)? "s employer identification number as shown on Form 5500 declars that I have examined this schedule, and to the best of my knowledge and belief it is true, co	
Ilduciary >	100 Harris 10/5/2	rreot, and complete.
For the Paperwork Raduct see the instructions for Fo	ion Motice and CMB Control Numbers, v6.1 S mm 6609 or 6500-EZ.	chedule P (Form 5500) 2003





SCHEDULE R (Form 5500)	ĺ
milinant of the Treasury lemai Revenue Service	- 1
Contraduct of Labor	

Retirement Plan Information

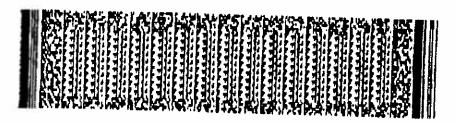
This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Security Act of 1974 (ERISA) and section 6055(a) of the Internal Revenue Code (the Code).

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Official Use Only

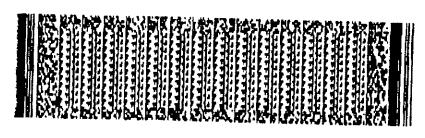
OMB No. 1210-0110

Person Barrell Guaranty Corporation	File as an Attachment to Form	55 00 .		This Fo	rm is Open to
For calendar year 2003 or flecal pla	n year beginning	and ending		L LIDRE	inspection.
A Name of plan			There is	-0	
BLAGNOSTIC & CLINICA	L CARDIOLOGY, P.A. MONEY PURCHAS	•	Three-di	- 1	00
C Plan sponsor's name as shown	on line 2s of Form 5500	-	phon num		
DIAGNOSTIC & CLINICA	L CARDIOLOGY, P.A.	10	Employ	er Identificati	ion Number 22-232399(
Pana Distributions					22-232399
All references to distribution	s relate only to payments of benefits during the plan yes	·····			
· · · · · · · · · · · · · · · · · · ·	in properly other than in cash or the forms of properly specific	7. ud	1 1		
THE REPORT AND THE PERSON OF T	*********				
Enter the E(N(s) of payor(s) wh	o peld benefits on behalf of the plan to participants or benefici	· * * * * * * * * * *	FOR THE REAL PROPERTY.	No. of the least	A. F. Will Co., Comp.
consult and home (in motes firm) (W	o, enter EINs of the two neutra who naid the avertage dates.				建筑的
Or Desire little		S-CENTS		经营业	
Profit-sharing plans, ESOPs,	and stock bonus plans, skip line 3.		82.14		学 , 生态设计
 Number of participants (living or 	deceased) whose benefits were distributed in a single sum, d	.	WHAT I	HEROSE .	
T P POOT YEE	****************************		633243	DESCRIPTION OF THE PARTY OF THE	報の表別を開
Exercise Funding Inform	ation (if the plan is not subject to the minimum funding request 302, 300 this Part		13		
Code or ERISA section	on 302, skin this Part)	remems of section	1412 of th	e internal Ray	enue
4 Is the plan administrator making	an election under Code section 412/cVRt or EDISA continue	201.370.0			
In contrast and additional freshellt	print, go to tine 7.	U2(c)(8)7	*******	∐ Yes 🗵	INO LINIA
5 if a waiver of the minimum fundi	ng standard for a prior year is being amoutived in this				
han hear and esstinicious and	miler the date of the miles teres arrested the con-				
is know committed into p' courb;	References 3, 9, and 10 of Schools to any or and a		Month	Day	Year
		the remainder of		idule.	
D Enter the amount contributed by	the employee to the nine for this of-	••••••••	6a 3		720018
C. Subtract the amount in line 6b fro	orn the amount in line Ga. Enter the result (enter a minus sign t	***********	5b \$		720018
	* * * * * * * * * * * * * * * * * * * *	o the left			
if you completed fine Sc, do no	it complete the remainder of this achiequie.		6c \$		0
 If a change in actuarial cost meth 	od was made for this other years assessment to				
approval for the change or a plass	ruling letter, does the plan sponeor or plan soministrator some	re providing autom			
			}	Yes	No NA
If this is a defined benefit pension	plan, were any amendments adopted during this plan year tha	-			
The second of th	FOR FULL INCOME I			_	
or Paperwork Reduction Act Notic	se and OMS Control Numbers, see the instructions for Fo			Yes	
	the districtions for the	4771 550 0 , v6	.1 Sch	edule R (Fors	n 6600) 2903





Γ				849436 147.08 03	54 .0012
	SCHEDULE T (Form \$500)	Qualified Pension Plan Coverage Informat This form is required to be filed under section 8058(a) of the Internal Revenue Code (the Code).	lon	OMB No. 12	210-0110
-	Department of the Treasury Internet Revenue Sensce	File as an attachment to Sam ages		This Form I Public In	s Open to
Fo	calendar year 2003 or fisc	al plan year beginning and ending			PACIFIC
A DI	Name of plan AGNOSTIC & CLIN	ICAL CARDIOLOGY, P.A. MONEY PURCHASE	B Thre	e-digit	<u> </u>
C	Plan sponsor's name as s	nown on line 2s of Form 5500 ICAL CARDIOLOGY, P.A.		number > Nover identificat	002 Ion Number 2-2323990
1 1a	in a plan maintained by m	ited to provide coverage information regarding the noncollectively bargained employes ore than one employer, enter the name and EIN of the participating employer;		ployer participation	
2	If the employer maintainin	g the plan operates QSLQBs, enter the following information:			
a	Lus unapper of d2f08s	hat the employer operates is			
Þ	The number of such QSL	OBs that have employees benefiting under this plan is			
d d	If the entry on line 2b is to	he minimum coverage requirements to this plan on an employer-wide rather than a Q to or more and fine 2o is "No," identify the QSLOB to which the coverage information	given on šn	ls?	Yes Ho
3	Exceptions - Check the bill you check any box, do	ox before each statement that describes the plan or the employer. Also see instruction not complete the rest of this Schedule.	ns.	· · · · · · · · · · · · · · · · · · ·	
a b c d	The employer employs No HCEs benefited un The plan benefits only The plan benefits all re	only highly compensated employees (HCEs) due the plan et anytime during the plan year, collectively-burgained employees, prescludable nonhighly compensated employees of the	tractions 4	Add to and to	
ę	The plan is treated as	satisfying the minimum coverage regularments states of	oversity 4	40)' (e)' 900 (W	1),
For #	aperwork Reduction Act	TVOICE MIS CORPO CORPO NUTTIONS CON the Instruction of the	6.1 Si	chedule T (Form	6600) 2003
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Γ	Schedule T (Form 5500) 2003		Page 2		34043654 147.06.0013
4	Enter the data the plan year began for which			2.1	Otheral Use Only
a			Month 31	Day 01	Year 2003
ь	Old any leased employees perform services in testing whether the pipe calledge the course.	LOS THE BUILDINGS IN SILA THE GRAND FUE	plan year?		Yes WHO
c	does the employer aggregate plans?	*************	***************************************	(4), 	🕽 Yes 🛭 No
	(1) Total number of employees of the empli				
	leased employees and self-employed in			5(1)	38
	(2) Number of excludable employees as de	fined in IRS regulations (see instruction	s)	c(2)	0
	(3) Number of nonexcludable employees. (Subtract line 4c(2) from tine 4c(1)}		c(3)	38
	(4) Number of nonexcludable employees (8	ne 4c(3)) who are HCEs		¢(4)	14
	(8) Number of nonexcludable employees (8	Ne 4c(3)) who benefit under the plan \dots	***** ***********	c(5)	36
_	(6) Number of benefiting nonexcludable en	ployees (line 4c(5)) who are HCEs		c(6)	14
đ	Enter the plan's ratio percentage and, if applintormition on lines 4c and 4d pertains (see	instructions) >		d	91.7
e	identify any disaggregated part of the plan a	nd enter the ratio percentage or exception	in (see instructions),		
	Disappregated part:	Ratio Percantage:	Exception:		
	(7)				
	(2)				
	(3)				
1	This plan satisfies the coverage requirement	a on the basis of (check one):	1) X the ratio percentage test	(2) [] :	Werlige benefit test

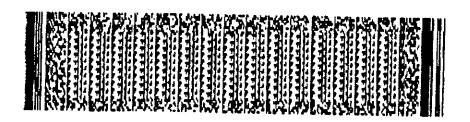




EXHIBIT 75

				1 2
Form 5500	Annual Return/Repor	t of Employee a	** *****	
Department of the Treesury Internet Revenue Service	This form is required to be filled un Retirement income Security Act	tier sections 104 and anea of	etit Plan	Official Use Only OMB Nos. 1210 - 0110
Copertment of Labor Employee Senefits Security	Retirement Income Security Act 6057(b), and 6058(a) of the	of 1974 (ERISA) and section	r une comployee ≤ 6047/a).	1210 - 0080
AGTHORIESTIN .	· · · · · · · · · · · · · · · · · · ·	CONTROL PROPERTY CALLS AND ALLE	Code).	2004
Pension Benefit Queranty Corporation Part Approval Proposition	the instance of	ntries in accordance with ns to the Form 5500.	·	This Form is Open to
For the calendar plan years one	t identification information	12 13 FORTH 5500.		Public Inspection.
For the calendar plan year 2004 A This return/report is for: (1)	UT IISCH DIAN Vear beginning	and e	tufino	
, ,	a multiemployer plan; a single-employer plan (other than a		lliple-employer plan;	~
	multiple-employer plan);	(4) 🔲 a DF	E (specify)	
B This return/report is: (1)		_		
(2)	the first return/report filed for the plan; an amended return/report;	(3) Lithe fir	al return/report filed	for the nime
C if the plan is a collectively-bargai	ned share at the con-	(4) 1 18 500	f nian imar salaaa	on the plan; ont (less than 12 months)
an extension of time	e or the DEVC program about	the state of the s	· · · · · · · · · · · · · · · · · · ·	·····»
id Nameoroban	THE REPORT OF THE PERSON NAMED IN COLUMN 1	tion.	instructions)	·····
DIAGNOSTIC & CLINICAL	CARDIOLOGY.		1b Three-digit	
P.A. MONEY PURCHASE P	LAN		plan number	(PN) > 002
			1c Effective date	of plan (mo., day, yr.)
2a Plan sponsor's name and add			04/01/1976	
(Address should include morn or DIAGNOSTIC & CLINICAL	s (employer, if for a single-employer plan) suite no.)		2b Employer Iden	tification Number (EIN)
CARDIOLOGY, P.A.	<u>.</u>			22-2323990
	• •	1	2c Sponsor's telep	973-731-9442
769 NODWETTER		[7	2d Business code	(see instructions)
769 NORTHFIELD AVENUE			Dependent on the second	621111
Man		- 1		
WEST ORANGE	NJ	07052-0000		
Under penalties of parlary and other penalties	NJ plets filing of this return/report will be asset set forth in the instructions, I declare that I have one	and the land to th	而倒居我們所以	
as the electronic version of this return/report if it is to	please (Bing of this return/report will be asse set forth in the instructions, I declare that I have asse eing filed electronically, and to the best of my knowle	mined this return/seport, including scoo	na established.	
SIGN A6	10/././			envests and attackments, as well
Signature of plan administra	tor Office	MARIO CRISCITO, 1	f.D.	
SIGN ///2 A	Contract of the contract of th	Type or print name of indivi	dual signing as plan	administrator
Signature of employer/plan spons	follow .	MARIO CRISCITO, M		
For Paperwork Reduction Act Notice	Date Date	Type or print name of individual sign	TO SE CONTRACT NAME OF	
For Paperwork Reduction Act Notice a	in Own Control Numbers, see the ins	tructions for Form 5500.	v7.2	
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SCHEDULE ! (FOrm 5500)
operation of the Treasury
internal Revenue Service

Department of Labor Employee Benefits Security Administration

Financial Information - Small Plan

This schedule is required to be filed under Section 104 of the Employee Retirement income Security Act of 1974 (ERISA) and section 6058(s) of the Internal Revenue Code (the Code).

File as an attachment to Form \$800.

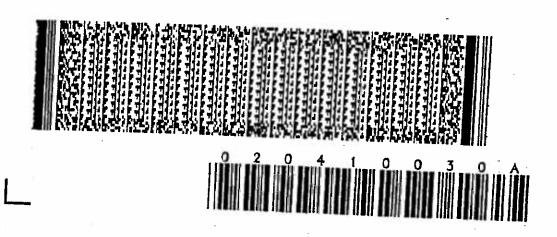
Official Use Only OMB No. 1210-0110

Pension Benefit Guaranty Corporation	file as an :	attachment	to Form 5500.		i		
For calendar year 2004 or flacet plan years be						This Form	is Ope
			and end	ina		to Public In:	pecilo
DIAGNOSTIC & CLINICAL CAR	TOLOGY n		जार बाद				
Plan sponsor's name as shown on line 2s	P.A. MONEY	PURCHA	l	B Thre			
DIAGNOSTIC & CLINICAL CAPO	or Form 5500			P	number		
omplete Scherk le I II the stee	TOLOGY, P.A.			O Emp	loyer id	entification Nu	nber
re filling as a small plan under the AC 420	than 100 participants as of the	heninning of	· ·			22-	-232
complete Schedule I if the plan covered fewer re filing as a smell plan under the 80-120 per Small Plan Financial In	dispant rule (see instructions). C	ompiete Sci	um pran year. You harhile lil if second	may also c	omplete	Schedule I if you	1
	- Commidtion				P-01 G	UIE.	
the of plan assets held in more than	abilities, income, emenee to						
eport below the current value of assets and it itue of plan assets held in more than one trus ny a specific dollar benefit at a future date, inc y payments/receipts to/from insurance carrie Plan Assets and Liabilifies.	t. Do not enter the value of the p	ortion of an i	anges in net asset	a during the	plan ve	ar Combine the	
y paymenta/receipta to/trom insurance carrie Plan Assets and Liabilities	Ride all income and expenses of	the plan inc	studios any manda	that guaran	tees du	ing this plan year	r to
Plan Assets and Liabilities:	a. Round off amounts to th	e nearest d	oller.	or sebarate	y maint	zined fund(s) an	d
Total ales		WAR TO SERVE					
Total plan liabilities		1a	(a) Beginning	Of Year		(b) End of Ye	
Net plan assets (subtract line 1b from line		10		8462930		95	6502
Income. Expenses	fa)	1c		0			
Income, Expenses, and Transfers for the Contributions received or receivable	ila Plan Year:			3462930		95	6502
/4\ E===		and the second	(a) Amou	rit		(b) Total	
123 Doubleton	• • • • • • • • • • • • • • • • • • • •	2a(1)		70774			-
(3) Othern (backet)		2a(2)		767706	HERE	对于人员	
Monorali anni il il il il il il il il il il il il il		2a(3)			1		
Other income	*****************	2b					4
Total income (artif Fram Corte) or an	**********	2¢		376384	153		
Total Income (edd lines 2s(1), 2a(2), 2a(3), 2 Benefits paid (including direct rollovers)	2b, and 2c)	2d	OF BURNINGS	3/0384		正是是由今美	MI FE
Corrective distributions (see instructions)		20	在"四天汉 "。			114	4090
		21			2000		28.00
Certain deamed distributions of participant to Other expenses	ans (see instructions)	20			100		
otal expenses (add lines 2s, 2f, 2g, and 2h)		2h		10000			
et income (loss) (subtract line 21 from line 2c		21	Part Address of the last	42000		周元的达到	
ransfers to (from) the plan (see instructions)		1509	建 基础的设计器			42	000
pecific Assets: If the plan held meets of						1102	090
The of any assets remaining in the plan as of	the and of the plan year in any	of the follow	ing categories	经的数据			
enters to (from) the plan (see instructions) pecific Assets: if the plan held assets at an time of any assets remaining in the plan as of a assets of more than one plan on a line-by-inthership/joint venture interests:	ine basis unless the trust master	te the value	of the pian's intere	et in a corre	nd erger ningland	the current	
irtnership/joint venture interests			haciac exceptions	described it	the ine	ruottone.	
ployer real property				19 1 140		Amount	
Count Barbart		••••••	3a	X			
Constitution Act Notice and OMB C	ontrol Numbers, see the		3b	X			
perwork Reduction Act Notice and OMB C	and the Nisti	uctions for	Form 5500.	v7.2.	Cherter	01/For- 725-	-
A SATERICA JEST IN MAIN IN A RESIDENCE				- \	r wu (1)	e i (Form 5500)	2004
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	1
Form 5500 (2004)	1
3a Plan administrator's name and administrator	
3a Plan administrator's name and address (if same as plan sponsor, enter "Same")	Official Use Only
3b Administr	ator's EIN
3c Administr	itor's telephone number
	and the state of t
4 If the name and to City Ja	
THE REPORT OF THE DOTT THE DOT	
EIN and the plan number from the last return/report below: a Sponsor's name.	D EIN
5 Preparer information (optional) a Name (inch witee for	C PN
AMERICAN PENSION CORPORATION A Name (including firm name, if applicable) and address	D EIN
1375 PLAINFIELD AVENUE	
	22-2141197
WATCHUNG	C Telephone number
6 Total number of participants at the beginning of the plan year	908-757-5151
to produce as of the end of the plan year (welfare plans as	308-737-5151
a Active participents	ALL CONTROLS
The state of the property of the state of th	a 45
G Subulga, Add lines 7s 7h and 9s	
G UECONSON Continues and the second continues	
Total, Add lines 7d and 7a	
g Number of participants with account balances as of the end of the plants with account balances as of the end of the plants.	
COMPlete this tem)	49
Number of participants that terminated employment during the plan year with accrued benefits that were less than	49
1 Gity (ARICCIDATE(S) Senterstart from Annals	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated 7h participants required to be reported on a Schedule SSA (Form 5500)	0
U Daniel Diuvini inche ma nine /	
a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the Western benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the Western benefit (check this box if the instructions): 2	0
b Wetture here the (check this how the	List of Plan
b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the Characteristics Codes printed in the instructions):	
	at of Plan
9al Plan funding arrangement (check all that apply)	-
(1) Insurance Pan benefit arrangement (check all that annu-	
(2) Code section 412(i) insurance contracts (1) Insurance	
(3) K Trust (4) General assets of the sponsor (3) K Trust (2) Code section 412(i) insurance contract (3) K Trust	ts
(4) General assets of the sponsor	. H
THE RELIES OF THE SPONSOR	
新作品(15年) (15年)	
AND A CONTRACT OF THE PROPERTY	
0 2 0 4 1 0	

Form 5500 (2004)	Page 3
Schedulee attached (Check all applicable boxes and, where indicated, en a Pension Benefit Schedules	for the number offended in
(1) R (Retirement Plan Information) (2) I T (Qualified Pension Plan Coverage Information) if a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year (3) B (Actuarial information) (4) E (ESOP Annual Information) SSA (Separated Vested Participant Information)	b Financial Schedules (1) H (Financial Information) (2) X I (Financial Information – Small Plan) (3) X 1 A (Insurance Information) (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information) (8) G (Financial Transaction Schedules) (7) X 1 P (Trust Fiduciary Information)



SCHEDULE R (Form 5500)

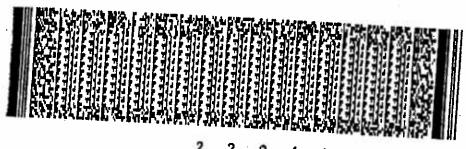
Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Security Act of 1974 (ERISA) and section 6058(a) of the internal Revenue Code (the Code).

Official Use Only

OMB No. 1210-0110

Pension Benefit Guaranty Corporation	Transmit revenue Code (the Code),	110	20	04
For calendar year 2004 or flacet plan year	File as an Attachment to Form 5500.		This Form	is Open to
		the state of the s	Public Ins	pection.
DIAGNOSTIC & CLINICAL CA	RDIOLOGY			
C Plan sponsor's name as shown on line	P.A. MONEY PURCHAS	B Three-digit		
DIAGNOSTIC & CLINICAL CA	PDTOLOGIC	Plan numb	er >	00
Part Distributions	DIOLOGI, P.A.	D Employer	identification i	Number
All references to distribute			22	-232399
1 Total value of distributions and the	e only to payments of benefits during the plan year,			
in the instructions	e only to payments of benefits during the plan year, arty other then in cash or the forms of property specified			
2 Fotor the Eleven of	A brobark sheciled	1 1		
disting the same of any or (s) who paid b	enests on behalf of the plan to participants or beneficiaries	1		
of banefits),	enetits on behalf of the plan to participants or beneficiaries EINs of the two payors who paid the greatest dollar amounts		等于现在的	PERSONAL PROPERTY.
O DEFENDED.	he had my best the diseasest dogs, smorte			建
PIDITI-Sharing plane, ECOD-		建		
 Number of participants (living or decess) 	ck bonus plans, skip line 3. ed) whose benefits were distributed in a single sum, during	一种	a sa in fair	
Funding Information	If the plan is not subject to the minimum funding requirements of		年美国型研究	
plan year, san instructions and audit	ard for a prior year is being amortized in this date of the ruling letter granting the waiver		Yes No	LINA
at Enter the minimum required contribution for D Enter the amount asset that	or this plan year	der of this schedule	Ya	
b Enter the amount contributed by the emplo C Subtract the amount in line the from the amount in	yer to the plan for this plan	6a s	7	57706
Subtract the amount in line 6b from the am	yer to the plan for this plan year count in line 6a. Enter the result (enter a minus sign to the left	6b s		57706
of a negative amount)	and result (enter a minus sign to the left		7,0	37706
		6c s		_
ir a change in actuariel cost method was me	orie for this class was screening.	<u> </u>		0
	And the Diet Appl Division for a service			
approval for the change or a class ruling left	of cines the size of the size of the size of the providing	Bulometic		
	te the remainder of this schedule. ace for this plan year pursuant to a revenue procedure providing ter, does the plan sponsor or plan administrator agree with the ch	Eulomatic		_
If this is a defined benefit pension rise.	au au au win the ch	enge? Y	es No	□ N/A
If this is a defined benefit pension plan, wen	any amendments adopted during this plan areas.	enge? Y	es No	□ N/A
If this is a defined benefit pension plan, wen	any amendments adopted during this plan areas.	enge? γ		O N/A
If this is a defined benefit pension plan, wen	au au au win the ch	Manger? ∐ Y		





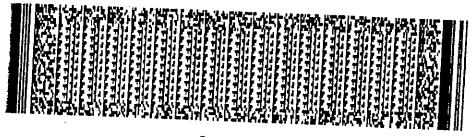
SCHEDULE T	
(Form 5500)	

Qualified Pension Plan Coverage Information

required to be filed under section 8058(a) of the internal Revenue Code (the Code).

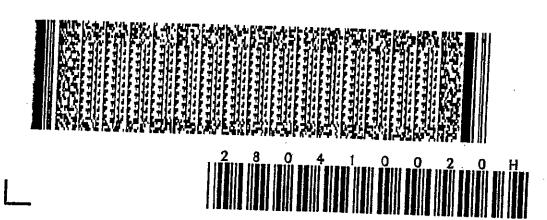
Cificial Use Cnty OMB No. 1210-0110

Department of the Treasury	Internal Revenue Code (the Code),	the		2004		
Internal Revenue Service	For calendar year 2004 or fiscal plan year beginning					
A NEMBOTON	Total Basic Rivery	Ing		a inspection.		
	ICAL CARDIOLOGY, P.A. MONEY PURCHASE hown on line 2a of Form 5500	В	Three-digit			
DIAGNOSTIC & CLIN	ICAL CARDIOLOGY, P.A.	D	plan number >	00		
WORE: If the plan is maintained	Page 1	I .	Employer identif	77-774AA		
each QSLOB (see the instri	of benefits employees who are not collectively-bargained employees, a separatruction for line 1). qualified separate lines of business (QSLOBs) under Code section 414(r), a uction for line 2). led to provide coverage information regarding the noncollectively bargained one than one employer, enter the name and EIN of the participating employer bloyer.	separate Sch employees of a		or ulred for atting		
b The number of such QSLC c Does the employer apply th d if the entry on line 2b is two if you check any box, do if you check any box, do if No HCEs benefited und The plan benefits only or	the plan operates QSLOBs, enter the following information: not the employer operates is DBs that have employees benefiting under this plan is eminimum coverage requirements to this plan on an employer-wide rather to or more and line 2c is "No," identify the QSLOB to which the coverage information or the employer. Also see in the before each statement that describes the plan or the employer. Also see in not complete the rest of this Schedula. only highly compensated employees (HCEs), or the plan at anytime during the plan year.	rmation given (structions,	on line 3 or 4 relates			
	excludable nonhighly compensated employees of the employer (as defined it as and self-employed individuals. disfying the minimum coverage requirements under Code section 410(b)(6)(otics and OMB Control Numbers		ns 414(b), (c), and (m)),		
, Nouselon ACI N	otice and OMB Control Numbers, see the instructions for Form 5500.	v7.2	Schedule T (For	n 5500) 2004		





4	Schedule T (Form 5500) 2004		Page 2			al line Out	
a b	does the employer aggregate plans? Complete the following:	s for the employer at any time during the pla erage and nondiscrimination tests of Code	sections 410(b) and 401(a		Day <u>01</u>	Year 2 Year 2 Yea	004 N N
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	Olsaggregated part: (1) (2) (3) This plan satisfies the coverage requirement:	Ratio Percentage:	Exception: the ratio percentage test)∏ aversge		



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